

FEM Centre
Joseph McWherter, M.D., P.A. and Associates
709 West Leuda, Fort Worth, TX 76104
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034

| | | | |
|------------------------------|--|---|----------------------------|
| Patient Name _____ | | Date of birth _____ | |
| Address _____ | | City _____ | State _____ Zip _____ |
| Home Phone _____ | | Alternate phone _____ | |
| Soc. Sec. # _____ | | Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| Employer _____ | | Position _____ | |
| Street Address _____ | | | |
| City _____ | | State _____ | Zip _____ Work phone _____ |
| Notify in an Emergency _____ | | Phone _____ | |
| Referred by _____ | | Religion _____ | |
| Drug Allergies _____ | | | |
| Email Address: _____ | | | |

| | | | |
|---------------------------|--|---------------------|----------------------------|
| Spouse Information | | | |
| Name _____ | | | |
| Address _____ | | City _____ | State _____ Zip _____ |
| Home Phone _____ | | Date of Birth _____ | |
| Employer _____ | | Position _____ | |
| Street Address _____ | | | |
| City _____ | | State _____ | Zip _____ Work phone _____ |

| | | | |
|-----------------------------------|--|---------------------------|-----------------------|
| Insurance Plan Information | | | |
| 1. Plan Name _____ | | Ins. Effective Date _____ | |
| Street Address _____ | | City _____ | State _____ Zip _____ |
| Policy ID _____ | | Policy Owner _____ | Group No. _____ |
| Telephone No. _____ | | | |
| 2. Plan Name _____ | | Ins. Effective Date _____ | |
| Street Address _____ | | City _____ | State _____ Zip _____ |
| Policy ID _____ | | Policy Owner _____ | Group No. _____ |
| Telephone No. _____ | | | |

| | |
|---|-------------|
| “I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any and all claims.” | |
| _____ | |
| Patient or Authorized Signature | |
| “I request payment of this claim and, if the payer accepts assignment, I authorize payment directly to the physician or supplier for the services described.” | |
| _____ | |
| Insured Signature | Date |

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Male Evaluation

Name _____

Age _____ DOB _____

Date _____ Occupation _____

List three main concerns that you would like to address in their order of importance:

1) _____

2) _____

3) _____

Other concerns: _____

Height _____ Weight _____ BP _____ P _____

Temp. _____ Smoker? Yes No

Allergies _____

Current medications _____

Past medical history _____

Past surgeries _____

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Name _____

Date _____ DOB _____

Testosterone Questionnaire

Rating Scale: 0 – not present/the same/no concern . 1 – significant difference/of some concern . 2 – much worse/of serious concern

Mental Function

- Feeling stressed or “burned” out
- Feeling depressed or negative
- Feeling irritable or angry
- Feeling anxious or nervous
- Feeling mentally fatigued, unable to concentrate
- Decreased mental sharpness, wit, attention
- Forgetful, poor memory
- Decreased assertiveness and/or competitiveness
- Loss of motivation or initiative to start new projects, participate in hobbies
- Feeling that work, relationships, and hobbies have lost significance
- Total Score**

Musculo-skeletal

- Fatigue or loss of energy particularly in the afternoon
- Feeling sore all over, aches in joints and muscles
- Frequent back or neck pain
- Decrease in physical stamina or endurance
- Decrease or less than optimal muscle size, tone, and strength
- Decrease in athletic performance, loss of agility, quickness
- Decline in flexibility and mobility
- Difficulty in recovering from physical exercise
- Increase tendency toward muscle pulls or leg cramps
- Osteoporosis
- Neuropathy
- Total Score**

Sexual Function

- Decrease in spontaneous early morning erections
- Decreased libido or desire for sex
- Decrease in fullness of erection
- Decreased volume or strength of force of climax
- Difficulty in maintaining full erection
- Difficulty in achieving an erection
- Premature ejaculation
- Total Score**

Urological Problems (1=yes, 0=no)

- I have a history of adult mumps, epididymitis or other testicular problems
- Enlarged prostate
- Urinary frequency, reduced flow, or forced flow
- Urination at night > 1x = 1, 2x = 2, etc.
- Decrease in urine flow, dribbling
- Take Proscar or other medicine for enlarged prostate
- Increased PSA
- I have had a prostate operation
- Inflammation or infection of the prostate
- I have had a vasectomy or a varicocele
- Infertility problem
- Hernia repair
- Seizure disorder (epilepsy)
- Total Score**

Physical Problems

- Shortness of breath with activities
- Lightheadedness, dizzy spells, ringing in the ears or frequent headaches
- Poor circulation in legs, swollen ankles, varicose veins or hemorrhoids
- Changes in visual acuity, ability to read fine print
- Dry skin on face or hands
- Excessive sweating during the day or at night
- Total Score**

Metabolic Disease

- Increase in total cholesterol or triglycerides
- Decrease in HDL cholesterol
- High blood sugar or diabetes
- High blood pressure
- Development of chest pain, heart disease, blocked arteries
- Unexplained weight gain, particularly in the midsection
- Increased fat in the chest or hip area
- Thyroid problem
- Total Score**

Miscellaneous Health Problems, Habits (1=yes, 0=no)

- History of heart disease, bypass surgery, PTCA
- Family history of CAD, bypass, stroke, early death
- Smoke packs per day (1, 2, 3, etc.)
- History of heavy drinking, treatment for alcohol or drug abuse
- Alcohol intake daily (occasional, 1, 2, 3, drinks/day)
- Used or using Marijuana
- Regular medicines:
 - diuretic beta-blocker verisimilar
 - anti-anhythmic seizure drug
 - anti-depressant Viagra
 - diabetes drug prednisone
 - stomach acid inhibitor vitamin with iron
 - prochromones (CHEA, Androstenedione, Stacks)
 - Other _____
- Asthma or emphysema
- Sleep apnea
- Degenerative or rheumatoid arthritis
- Crohn's disease or ulcerative colitis
- Treatment with prednisone in past
- Used or prescribed testosterone or anabolic steroids
- Chronic fatigue syndrome/fibromyalgia
- Lyme disease
- HIV/AIDS
- Received treatment for any cancer
- Multiple sclerosis or neurologic problems
- Parkinson's disease
- Hemocromatosis (iron overload)
- Total Score**

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Patient Policy

Arriving for your appointment: We understand that situations arise that might cause you to arrive late for your scheduled appointment. The courtesy of a phone call informing us that you may be late is appreciated. Efforts will be made to still see a patient who arrives late. However, you may have to wait until you can be worked in. In some situations, it may be necessary to reschedule.

New patients are expected to arrive at least 30 minutes prior to your scheduled time to complete paperwork. If paperwork has been completed prior to the appointment day, new patients should arrive at least 15 minutes early.

Appointment confirmations: Confirmation calls are made in advance of scheduled appointments. If necessary, a message will be left requesting a return call. The courtesy of a response is appreciated. If you fail to confirm an appointment, that time could be given to another patient or you may be assessed a “No Show” fee.

No Show/Late Cancellation fee: We make every effort to make appointments for patients as requested. Therefore, all appointment times are precious. In the event that your confirmed or pending appointment needs to be rescheduled, we request 24 hours notice so we may offer the appointment time to a patient on our waiting list. Cancellations less than 24 hours in advance or “No Shows” are subject to a fee. This fee must be paid before a new appointment is scheduled.

Insurance cards/Personal information forms: It is necessary for us to keep all of our patient information current for insurance and other reasons. Because of this, you will be asked to update personal information and present your insurance card at least every 3 months. A photo ID will also be requested if none is present in the chart. It is suggested that you arrive 10 minutes prior to your scheduled appointment time to update forms.

Supplements: Unopened products may be exchanged or returned for a credit within 30 days of purchase.

Payment Policy

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in the bill for services becoming your responsibility.

Payment options if you have insurance: As a courtesy, we will file insurance claims for patients who present a valid insurance card.

We request that payment for co-pays, deductibles, and any out-of-pocket portions be paid at the time services are rendered by cash, check, or credit card (Master Card, Visa, American Express, and Discover are accepted).

You may choose to pay for all of your treatment by cash, check, or credit card and submit the claim to the insurance company yourself. If you choose this option, we will supply you with a copy of your Super Bill to submit your insurance carrier and they will send their payment directly to you.

Payment options if you DO NOT have insurance: We request that payment for all office visits and procedures be paid at time/date of service. You may choose to pay by cash, check, or credit card (Master Card, Visa, American Express, and Discover are accepted).

On extensive treatment (i.e. surgery), you may discuss with our billing department the option of a payment schedule.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

Re-billing Fee: A re-billing fee of \$10 will be imposed on each account that is over sixty (60) days past due. We determine your account is past due by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time.

Returned checks: There is a fee (currently \$25) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency or attorney, we will do so.

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Waiver of confidentiality: You understand if this account is submitted to a collection agency or attorney, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Co-signature: If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Disclosure of Patient Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone # _____

Name _____ Phone # _____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-rays results, or other health care information if other than your home or work number (such as a cell phone number*): _____

* I am fully aware that a cell phone is not a secure and private line.

Patient name _____
Please print

Patient/Guardian signature

Date _____

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Acknowledgement of Review of Notice of Privacy Practices

I, _____ have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

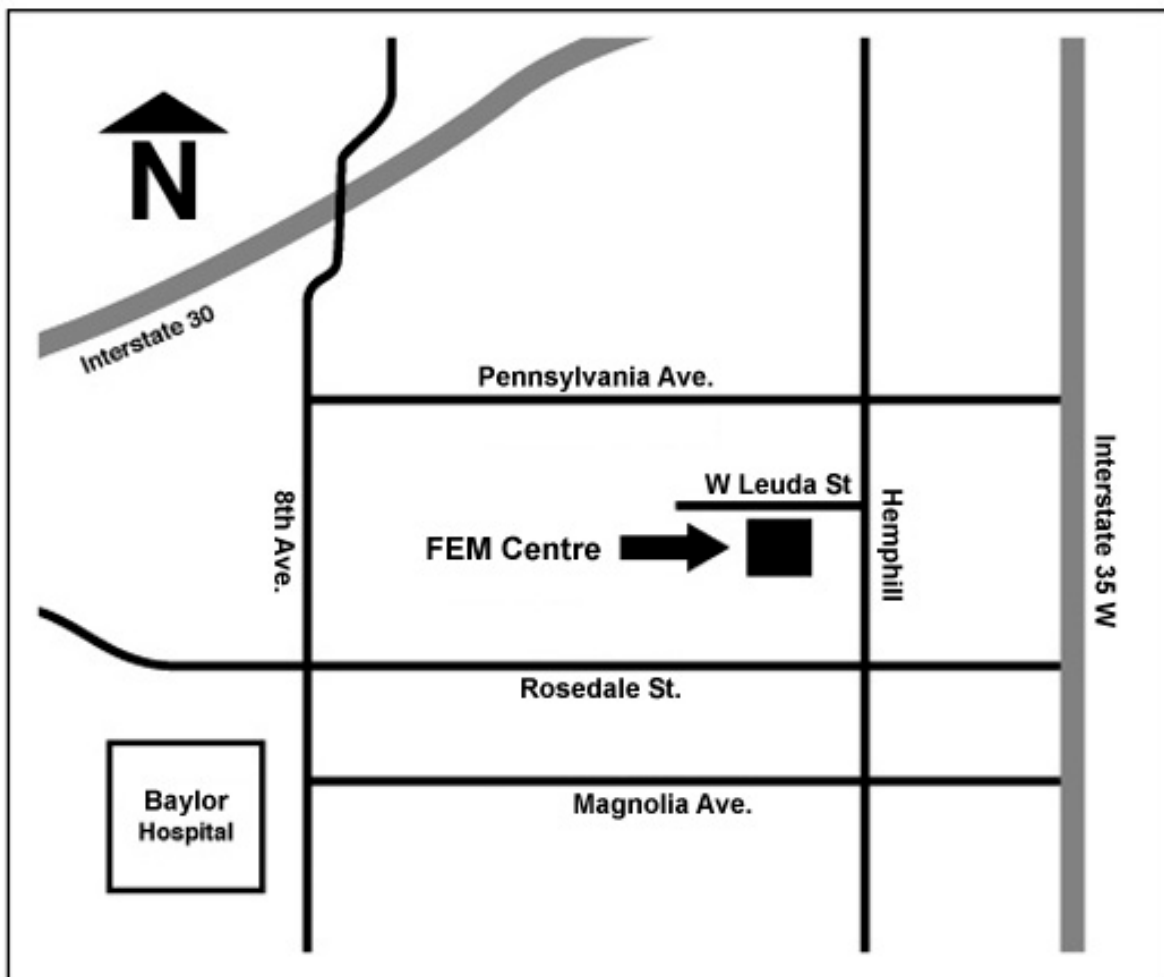
Signature of Patient or Personal Representative

Date

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Locating Our Fort Worth Office

Our office is located in a freestanding building at 709 West Leuda, three blocks north of Rosedale off Hemphill in Fort Worth, Texas. The map below shows you can reach our office from Interstate 35 by taking the Rosedale exit and going west to Hemphill.



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Locating Our Colleyville Office

Our office is located in the Colleyville Square Office Park in Colleyville, Texas. The map below shows you can reach us from:

- Highway 114: take the Ira E. Woods Ave. (Hwy. 26) exit south. Woods Ave. becomes Colleyville Blvd. when you enter the city of Colleyville. The Colleyville Square Office Park is 4 miles south of Highway 114 on your left.
- Highway 121: take the Hall-Johnson exit west to Colleyville Blvd., turn north and the Colleyville Square Office Park will be on your right.
- Northeast Loop 820: Take the Grapevine Highway (Hwy. 26) exit north. Grapevine Highway becomes Colleyville Blvd. when you enter Colleyville. The Colleyville Square Office Park is 6 miles north of Loop 820 on your right.

Our office is in Suite 100 at the northwest corner of the office park facing Colleyville Blvd.

