Idaho Center for Regenerative Medicine

ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!

6001 W. State Street, Suite B, Boise, ID 83703

208-995-2802 / 208-995-2804 (fax) / www.icrmboise.com

An Integrative Approach to Health, Wellness & Vitality

Welcome and thank you for your interest in the Idaho Center for Regenerative Medicine. Dr. Robert Haake is committed to support your journey to reach your unique optimal health goals. From a functional medical perspective, Dr. Haake's approach to patient care focuses on identifying underlying causes of disease using a systems-oriented approach.

Our approach is based on these key components:

- Bio-identical Hormone Replacement
- Macro nutrition/Paleo Diet
- Micronutrition/Supplementation
- Weight Training/Aerobic exercise
- Restorative Sleep

To reach your goal of optimal health, it is ***ESSENTIAL*** for you to embrace and actively participate using these key components in your lifestyle.

Our texting service will remind you to have your LABS DRAWN IN ADEQUATE TIME; however, ultimately, IT IS THE RESPONSIBILITY OF THE PATIENT TO KEEP TRACK OF WHEN TO GET YOUR LABS DRAWN, AS WELL AS YOUR SCHEDULED APPOINTMENT. Please

Be aware that LABS ARE INTREGAL to your treatment. You will need to have LABS DRAWN 10-14 DAYS PRIOR TO EVERY FOLLOW-UP APPOINTMENT.

Dr. Haake saves an entire hour for every appointment. If you are unable to get labs drawn in time or attend your scheduled appointment, PLEASE LET US KNOW ASAP SO WE CAN ACCOMMODATE OTHER PATIENTS.

Effective August 1, 2024 our office visit fees:

Robert Haake, DO

New Patient Consultation $550.00

Follow Up Visits $350.00

Cancellation Fees:

Less than 48 hours existing patient $150.00

Less than 72 hours new patient $150.00

All cancellations with less than 12 hours notice $200.00

Idaho Center for Regenerative Medicine

ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!

6001 W. State Street, Suite B, Boise, ID 83703

208-995-2802 / 208-995-2804 (fax) / www.icrmboise.com

WE REQUIRE THIS PAPERWORK IN OUR OFFICE 2-3 DAYS PRIOR TO YOUR SCHEDULED VISIT. PLEASE EMAIL TO FRONTDESK@ICRMBOISE.COM, FAX TO 208-995-2804 OR DROP OFF AT THE OFFICE.

(PLEASE NOTE: YOUR APPOINTMENT WILL NEED TO BE RE-SCHEDULED IF PAPERWORK IS NOT RECEIVED IN ADVANCE.)

Please Print Date _____

Mr. / Ms.

Last Name First Name Middle Initial Marital Status

Date of Birth Age

Address City State Zip

Home Phone Number / Cell Phone Number E-mail Address

Employed By Work Phone Number

Name of Spouse Employed By Work Phone Number

Emergency Contact Relationship to Patient Contact Phone Number

Who may we thank for referring you?

What is your chief problem or complaint?

PLEASE COMPLETE THE FOLLOWING HEALTH ASSESSMENT AS ACCURATELY AS POSSIBLE. PRIOR TO YOUR INITIAL APPOINTMENT, DR. HAAKE TAKES TIME TO THOROUGHLY REVIEW THIS INFORMATION TO OPTIMIZE THE TIME SPENT WITH YOU DURING YOUR APPOINTMENT!
WE THANK YOU!

PATIENT NAME: _____DATE: _____

1. CURRENT MEDICATIONS: (Name/Dosage/Frequency) _____

_____

_____

_____

_____

_____

_____

2. OVER-THE-COUNTER MEDICATIONS: (Name/Dosage/Frequency) _____

_____

_____

_____

3. VITAMINS / SUPPLEMENTS: (Name/Dosage/Frequency) _____

_____

_____

_____

_____

4. HABITS:

a) Smoking History: _____ Number of packs/day _____ Number of years _____ Quit _____

b) Alcohol: Number of alcoholic beverages per day/week _____

Type of alcohol: Wine _____ Beer _____ Liquor _____

c) Other Recreational Drugs: _____

d) Cell phone use (hours per day): _____

e) Antibiotic use (yearly / monthly, etc.): _____

f) Mercury fillings: Yes / No

PATIENT NAME: _____

5. SOCIAL HISTORY: a) Married ___ / Single ___ / Divorced ____ b) Number of Children _____

c) Job/Profession _____

d) Religion / Spirituality: _____ e) Primary Care Physician: _____

PATIENT NAME: _____DATE: _____

6. FAMILY HISTORY:

Is your father living? (Age _____) Died at age _____

Cause of death _____

Is your mother living? (Age _____) Died at age _____

Cause of death _____

Number of brothers living _____

Number of brothers deceased _____Cause _____

Number of sisters living _____

Number of sisters deceased _____ Cause _____

Age of spouse (if living) _____

If living, is spouse in good health? Yes No

Has anyone related to you had:	*Relative with this disease:*
Diabetes	
Cancer	
High blood pressure	
Heart disease	
Tuberculosis	
Glaucoma	
Cataracts	
Kidney disease	

7. ALLERGIES:

Drugs: _____

Other: _____

8. SURGICAL HISTORY:

List and date of any operations; if none, please check _____

Type: _____ Date _____

Type: _____ Date _____

Type: _____ Date: _____

Type: _____ Date: _____

PATIENT NAME: _____DATE: _____

9. TRAUMATIC HISTORY: (Fractures, etc.)

_____

10. (*Circle where appropriate):*

- Diabetes mellitus
- Thyroid disease (hypothyroid)
- Hypertension
- Obesity
- Arthritis
- Hyperlipidemia (high cholesterol)
- Coronary heart disease
- Angina
- Previous MI (heart attack)
- COPD (emphysema) or chronic bronchitis
- Obstructive sleep apnea
- Peptic ulcer disease
- Cancer (type)_____
- Other

GENERAL:

Do you usually have difficulty falling asleep?	Yes	No
Do you usually have difficulty staying asleep?	Yes	No
Do you often have severe fatigue?	Yes	No
Do you have loss of strength?	Yes	No
Do you have loss of muscle mass?	Yes	No
Have you gained body fat?	Yes	No
Do you have low energy levels?	Yes	No
Are you frequently ill?	Yes	No
Fever, chills or night sweats recently?	Yes	No
Do you have any chronic disease?	Yes	No
Do you have recurrent anxiety?	Yes	No
Have you had recurrent depression?	Yes	No
Have you ever been diagnosed with any other mental illness?	Yes	No
How often do you engage in exercise – **days per week**?	1 / 2 / 3 / 4 / 5 / 6 / 7	
What type of exercise do you do: walking, biking, weight lifting, running, yoga?	_____	

_____

When is the last time that you engaged in vigorous exercise? _____

NEUROLOGICAL: *Have you ever had?*

Frequent or severe headaches?				Yes	No
Fainting, loss of consciousness?				Yes	No
Clumsiness, incoordination?				Yes	No
Have you ever had seizures?				Yes	No
Dizziness?	Yes	No	Numbness?	Yes	No
Weakness?	Yes	No	Stroke?	Yes	No
Double vision?	Yes	No	Falling Episodes?	Yes	No

Other problems: _____

PATIENT NAME: _____DATE: _____

MEMORY SCREENING:

The following statements describe everyday life situations. Please rate how common each situation is for you by selecting one of the following: Daily, Regularly, Occasionally, Rarely, Never. Circle the corresponding number for each rating:

	Daily	Regularly	Occasionally	Rarely	Never
1. Forgetting where you have put something. Losing things around the house.	1	2	3	4	5
2. Failing to recognize places that you have been before.	1	2	3	4	5
3. Finding a television story difficult to follow.	1	2	3	4	5
4. Not remembering a change in your daily routine, such as a change in the place where something is kept, or a change in the time something happens. Following your old routine instead.	1	2	3	4	5
5. Having to go back and check whether you have done something that you that You meant to do.	1	2	3	4	5
6. Completely forgetting to take things with you, or leaving things behind and having to go back and fetch them.	1	2	3	4	5
7. Forgetting that you were told something yesterday or a few days ago, and having to be reminded about it.	1	2	3	4	5
8. Starting to read something (book, newspaper, magazine) without realizing you have already read it before.	1	2	3	4	5
9. Having difficulty picking up a new skill. For example, finding it hard to learn a new game or to work a new gadget after practice.	1	2	3	4	5
10. Finding that a word that is "on the tip of your tongue." You know what it is but just cannot find it.	1	2	3	4	5
11. Forgetting details of what you did or what happened to you the day before.	1	2	3	4	5
12. When talking to someone, forgetting what you have just said. Maybe saying "*What was I just talking about*?"	1	2	3	4	5
13. When reading a newspaper or magazine, being unable to follow the thread of a story, losing track of what it is about.	1	2	3	4	5
14. Getting details of what someone has told you mixed up and confused.	1	2	3	4	5
15. Telling someone a story or joke that you have told them already.	1	2	3	4	5
16. Forgetting details of things you do regularly, whether at home or work, for example, forgetting details of what to do or what time it is.	1	2	3	4	5
17. Forgetting where things are normally kept, or looking for them in the wrong place.	1	2	3	4	5
18. Getting lost or turning in the wrong direction on a journey, a walk or in a building that you are familiar with.	1	2	3	4	5
19. Repeating to someone what you have just told them or asking a question twice.	1	2	3	4	5
20. Doing some routine thing twice by mistake. For example, putting two bags of tea in the teapot, going to brush/comb your hair when you have already done so.	1	2	3	4	5

PATIENT NAME: _____ DATE: _____

EYES:

Has there been a change in vision recently?	Yes	No
Do you wear glasses?	Yes	No
Do you have glaucoma?	Yes	No

Have you ever had cataracts? Yes No
Have you ever had macular degeneration? Yes No

Other problems: _____

EARS:

Do you have deafness? Yes No
Have you had ringing in your ears (tinnitus)? Yes No
Do you have recurrent ear infections? Yes No

Other problems: _____

NOSE AND THROAT:

Do you have a history of sinus problems? Yes No
Do you have hay fever? Yes No
Have you had hoarseness or a change in your voice? Yes No
Do you have trouble swallowing? Yes No
Do you have pain with swallowing? Yes No
Do you see a dentist regularly? Yes No

Other problems: _____

NECK:

Have you had any thyroid trouble? Yes No
Do you have swollen glands in your neck? Yes No
Are there any masses in your neck? Yes No

Other problems: _____

LUNGS:

Have you had a recent chest x-ray and was it normal? Yes No
Do you have a history of asthma, cough? Yes No
Have you had recent fever, chills, chest pain? Yes No
Do you cough up mucous or pus? Yes No
Have you ever coughed up blood? Yes No
Do you have a history of pneumonia? Yes No
PATIENT NAME: _____ DATE: _____
Do you have a history of COPD or emphysema? Yes No
Do you have a history of sarcoidosis? Yes No
Do you have a history of lung cancer? Yes No

Other problems: _____

HEART:

Have you had chest pain?	Yes	No
Do you have chest pain with exertion?	Yes	No
Do you have chest pain with rest?	Yes	No
Do you have shortness of breath at rest?	Yes	No
Do you have shortness of breath with exertion?	Yes	No
Do you need to sleep on more than one pillow at night?	Yes	No
How many pillows do you use for sleep? _____		
Do you have swelling in your feet?	Yes	No
Do you have palpitations?	Yes	No
Has your blood pressure been elevated or so low that it has given you symptoms?	Yes	No
Have you had a previous heart attack?	Yes	No
Do you have a history of valvular disease?	Yes	No
Have you had rheumatic fever?	Yes	No
Have you ever had bypass surgery? Yes No How many vessels bypassed? _____		
Have you ever had an angioplasty and stent in your heart?	Yes	No
Have you had a pacemaker or defibrillator placed?	Yes	No
Do you have a history of hypertension?	Yes	No

GASTROINTESTINAL:

What is the most you have ever weighed? _____		
Have you lost weight recently?	Yes	No
Have you had any change in appetite?	Yes	No
Do you have a history of peptic ulcer disease?	Yes	No
Do you have a history of gastritis?	Yes	No
Have you ever had gallbladder disease?	Yes	No
Have you ever had liver disease?	Yes	No
Have you recently had abdominal pain, nausea, vomiting, diarrhea or constipation?	Yes	No
Have you ever been jaundiced?	Yes	No
Do you have recurrent heartburn?	Yes	No
Do you have recurrent vomiting?	Yes	No
Have you ever vomited up blood?	Yes	No
Do you have any history of bloody or black stools?	Yes	No
Do you have recurrent diarrhea or constipation?	Yes	No
Do you use laxatives?	Yes	No

PATIENT NAME: _____DATE: _____

Do you require laxatives?	Yes	No
Have you ever had hemorrhoids?	Yes	No
Have you ever had diverticulosis?	Yes	No
Have you ever had intestinal polyps?	Yes	No

Have you ever had colon cancer? Yes No

Date of last colonoscopy? _____

Any other gastrointestinal problems? _____

GENITOURINARY:

Do you urinate frequently? Yes No

Do you get up at night do you get up to urinate? Yes No

How often do you get up at night to urinate? _____

Do you ever have burning with urination? Yes No

Do you have urgency or frequency of urination? Yes No

Have you ever passed blood in your urine? Yes No

Is your urine frequently dark? Yes No

Have you had previous kidney stones? Yes No

Have you had bladder infections or urinary tract infections? Yes No

Do you sometimes lose control of your bladder? Yes No

Have you had a venereal disease? Yes No

Do you have erectile dysfunction? Yes No

Have you had any sexual dysfunction? Yes No

Is sex painful? Yes No

Do you have chronic kidney disease (CKD)? Yes No

Have you had acute renal failure? Yes No

Have you had glomerulonephritis? Yes No

Do you have hereditary kidney disease? Yes No

Other problems: _____

BONES AND JOINTS:

Have your joints ever been painful or swollen? Yes No

Do you get muscle cramps? Yes No

Do you have severe back or neck pain? Yes No

Do you have limitation with range of motion? Yes No

Do you have morning stiffness? Yes No

Are your smaller joints ever painful or swollen? Yes No

Have you had trauma to your joints? Yes No

Have you ever been diagnosed as having rheumatoid arthritis? Yes No

Have you ever been diagnosed as having osteoarthritis? Yes No

Other problems: _____

PATIENT NAME: _____ DATE: _____

SKIN:

Have you had skin rashes or itching? Yes No

Have you detected any lumps or growths on your skin? Yes No

Have you had any moles that have changed size or color or appearance? Yes No
Have you had any areas of bruising? Yes No
Do you bruise easily? Yes No

Other problems: _____

ENDOCRINOLOGIC:

Do you have any history of hyperthyroidism, hypothyroidism, adrenal problems, diabetes mellitus? Yes No
Do you have any history of pituitary problems? Yes No
Do you have problems with menstruation? Yes No
Problems with conception? Yes No
Have you had any problems with any of the other endocrine systems? Yes No

Other problems: _____

OB/GYN HISTORY

Number of pregnancies: _____
Number of deliveries: _____
Number of miscarriages: _____
Number of abortions: _____
Last menstrual period: _____

--Recurrent regular intervals: Y N
--Recurrent irregular intervals: Y N
--Heavy flow: Y N
--Normal flow: Y N
--Light flow: Y N
Postmenopausal: Y N
History of fibrocystic breast disease: Y N

History of polycystic ovarian syndrome: Y N
History of endometriosis: Y N
History of uterine fibroids: Y N
Previous hysterectomy: Y N
Previous ovarian resection: Y N
Menopausal: Y N
History of abnormal pap smear: Y N
Last pap smear: _____
History of abnormal mammogram: Y N
Date of last mammogram: _____
Do you perform self-breast exams monthly: Y N
Method of birth control: _____
Other: _____

Date of your last immunization for influenza: _____ Other: _____

Most recent oversees travel: _____

PATIENT NAME: _____ DATE: _____

⇧ E2/P4 – Increased estrogen to progesterone ratio – (*THIS PAGE FOR WOMEN ONLY)*

	None	Mild	Moderate	Severe
PMS	☐	☐	☐	☐
Agitation / Irritability	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Insomnia or very light sleep	☐	☐	☐	☐
Fluid retention	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
Fibrocystic breast disease	☐	☐	☐	☐
History of polycystic ovarian syndrome	☐	☐	☐	☐
History of uterine fibroids	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Muscle or joint pain	☐	☐	☐	☐
Heavy periods	☐	☐	☐	☐
Decreased libido	☐	☐	☐	☐
Gain in abdominal fat	☐	☐	☐	☐
Loss of bone or mineral density	☐	☐	☐	☐
History of gallbladder disease	☐	☐	☐	☐

⇩ E2/P4 – Decreased estrogen to progesterone ratio: (*FOR WOMEN ONLY)*

Hot flashes	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Brain fog or difficulty concentrating	☐	☐	☐	☐
Decreased memory	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Urinary incontinence	☐	☐	☐	☐
Palpitations	☐	☐	☐	☐
Decreased libido	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Decreased energy	☐	☐	☐	☐
Decreased bone mineral density	☐	☐	☐	☐

PATIENT NAME: _____DATE: _____

Do you have any of the following signs or symptoms? Please identify as none, mild, moderate or severe:

	None	Mild	Moderate	Severe
Weight (fat) gain	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐
Cold intolerance	☐	☐	☐	☐
Fatigue / low energy	☐	☐	☐	☐
Brain Fog	☐	☐	☐	☐
Dry skin	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Fluid retention	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Joint / muscle pain	☐	☐	☐	☐
Brittle hair	☐	☐	☐	☐
Thinning hair	☐	☐	☐	☐
Inability to sweat with exercise	☐	☐	☐	☐
Loss of appetite	☐	☐	☐	☐
Heavy menstrual flow	☐	☐	☐	☐
Palpitations	☐	☐	☐	☐
Cold hands or feet	☐	☐	☐	☐
Loss of hair on outer eyebrow	☐	☐	☐	☐
Worsening hearing	☐	☐	☐	☐
Recurrent headaches	☐	☐	☐	☐
History of high cholesterol	☐	☐	☐	☐
Low blood pressure	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
History of PMS	☐	☐	☐	☐
History of polycystic ovarian syndrome	☐	☐	☐	☐
Uterine fibroids	☐	☐	☐	☐
Erectile dysfunction	☐	☐	☐	☐
History of low body temperature	☐	☐	☐	☐
Goiter	☐	☐	☐	☐
History of slow heart rate	☐	☐	☐	☐
Swelling of the face	☐	☐	☐	☐
Swelling around the eyes	☐	☐	☐	☐
Hoarseness	☐	☐	☐	☐
Thick tongue	☐	☐	☐	☐
Profound fatigue	☐	☐	☐	☐
Difficulty recovering from exercise	☐	☐	☐	☐
Irritability or agitation	☐	☐	☐	☐

PATIENT NAME: _____DATE: _____

	None	Mild	Moderate	Severe
Salt cravings	☐	☐	☐	☐
Sugar cravings	☐	☐	☐	☐
Narcotic intolerance	☐	☐	☐	☐
Decreased libido or other sexual dysfunction	☐	☐	☐	☐
Joint or muscle pain	☐	☐	☐	☐
Food allergies	☐	☐	☐	☐
Other allergies like hay fever	☐	☐	☐	☐
Difficulty recovering from sickness	☐	☐	☐	☐
Frequent colds or bronchitis	☐	☐	☐	☐
Recurrent nausea or abdominal pain	☐	☐	☐	☐
Sleep disturbances / waking at night	☐	☐	☐	☐
Anaphylactic reactions to drugs or bee stings	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Chemical intolerance	☐	☐	☐	☐
Low blood pressure with standing	☐	☐	☐	☐

⇩ **T – Decrease in Testosterone:** ***(MEN AND WOMEN)***

	None	Mild	Moderate	Severe
Decreased energy	☐	☐	☐	☐
Decreased cognitive function	☐	☐	☐	☐
Decreased focus	☐	☐	☐	☐
Decreased stamina	☐	☐	☐	☐
Decreased libido	☐	☐	☐	☐
Increased body fat	☐	☐	☐	☐
Decreased muscle mass	☐	☐	☐	☐

PATIENT NAME: _____DATE: _____

ADULT GROWTH HORMONE DEFICIENCY, (AGHD):

Please identify as none, mild, moderate or severe:

	None	Mild	Moderate	Severe
Thin skin	☐	☐	☐	☐
Sagging skin	☐	☐	☐	☐
Wrinkles	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐
Graying Hair	☐	☐	☐	☐
Decreased short-term memory	☐	☐	☐	☐
Difficulty learning new information	☐	☐	☐	☐
Worsening presbyopia (near vision)	☐	☐	☐	☐
Anxiety/Depression	☐	☐	☐	☐
Poor or nonrestorative sleep	☐	☐	☐	☐
Decreased endurance	☐	☐	☐	☐
Increased belly fat	☐	☐	☐	☐
Increased visceral fat	☐	☐	☐	☐
Loss of muscle mass and strength	☐	☐	☐	☐
Decreased kidney function	☐	☐	☐	☐
Increased Cholesterol	☐	☐	☐	☐
Osteoporosis/osteopenia	☐	☐	☐	☐
Decreased immune function	☐	☐	☐	☐

NAME: _____ **DATE:** _____

DIETARY HISTORY:

How often do you eat breakfast? _____

What generally does breakfast consist of for you? _____

How often do you eat lunch? _____

What generally does lunch consist of for you? _____

How often do you eat dinner? _____

What generally does dinner consist of for you? _____

F -FREQUENTLY S -SOMETIMES R -RARELY N -NEVER

Refined carbohydrates:	F / S / R / N	Fat	
(high glycemic index carbohydrates)		--Omega 3 (EPA—DHA):	F / S / R / N
Fatty Food	F / S / R / N	--Omega 9 (monounsaturated fat):	F / S / R / N
Trans fats	F / S / R / N		
Fried foods	F / S / R / N		
High fructose corn syrup	F / S / R / N	Alcohol:	
Desserts/sweets	F / S / R / N	--Beer	F / S / R / N
Sugar	F / S / R / N	--Wine	F / S / R/ N
Grains	F / S / R / N	--Liquor	F / S / R / N
Gluten-free grains	F / S / R / N	--Coffee	F / S / R / N
Complex carbohydrates	F / S / R / N	--Soda	F / S / R / N
Protein:		--Energy drinks	F / S / R / N
-- Fish	F / S / R / N		
-- Beef	F / S / R / N		
-- Turkey	F / S / R / N		
-- Chicken	F / S / R / N		
-- Other _____	F / S / R / N		

I hereby certify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient Date

Idaho Center for Regenerative Medicine

ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!

6001 W. State Street, Suite B, Boise, ID 83703

08-995-2802 / 208-995-2804 (fax) / www.icrmboise.com

Thank you for choosing the Idaho Center for Regenerative Medicine for your healthcare. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. Please feel free to call our office if you have any questions concerning our policies.

OFFICE HOURS

ICRM office is open Monday through Thursday, 9:00 a.m. to 5:00 p.m.* The Clinic may be reached at (208) 995-2802. If we are with patients or not available, please leave a message on our voice mail and we will return your call as soon as possible or on the next business day. **Office hours above except for holiday office closures.*

APPOINTMENTS/CANCELLATIONS

To ensure quality care, ICRM's team of physicians do not treat patients they have not seen (i.e. will not call in prescriptions or offer medical advice for patients prior to an initial office visit). Follow up visits are scheduled after all testing/labs have been completed so that results may be reviewed together and an effective and appropriate plan for your healthcare can be determined. ***Please note that test results will not be given over the phone.***

YOUR APPOINTMENT TIME IS SET ASIDE JUST FOR YOU! WE DO NOT DOUBLE OR TRIPLE BOOK. THEREFORE, IF YOU ARRIVE MORE THAN 15 MINUTES AFTER YOUR SCHEDULED APPOINTMENT, YOU WILL NOT BE SEEN BY YOUR PROVIDER AND WILL NEED TO RESCHEDULE YOUR APPOINTMENT. YOU WILL BE CHARGED A $50.00 CANCELLATION FEE WHICH IS NOT REIMBURSABLE BY INSURANCE.

Cancellation Fees:

Less than 48 hours existing patient $150.00

Less than 72 hours new patient $150.00

All cancellations with less than 12 hours notice $200.00

Please let us know if you are unable to make your appointment and we will be happy to reschedule for you at your convenience. If you do not call and cancel your appointment a $150.00 fee will be charged. These charges are patient's responsibility and are not reimbursable by insurance. ***After the second late cancellation and/or no show we will ask you to seek care elsewhere.***

_____***Patient Initials***

PRESCRIPTION REFILLS & PHARMACY INFORMATION

PLEASE DO NOT CONTACT THE OFFICE FOR PRESCRIPTION REFILLS. We MUST receive the information via fax directly from your pharmacy. *If a prescription refill is needed, please call your pharmacy and have them fax the request to our office at (208) 995-2804. Requests will be processed within 24 to 48 business hours. If received on a Friday or over the weekend, the following Monday.*

Please note that prescriptions and refills will not be given to patients we are not able to monitor. If you do not have a follow up appointment and labs in the appropriate time frame we will, unfortunately, not be able to fill your prescriptions.

_____***Patient Initials***

INSURANCE

ICRM is a pay-for-fee clinic. As a courtesy to our patients, ICRM will provide you with forms and billing codes that you can use to file claims to your insurance carrier.

Please be advised that ICRM does not participate with Medicare or private insurance.

PAYMENTS

ICRM accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Payment is due at the time of service.

FORMS/LETTERS

We understand that, at times, various forms or letters may be required to assist you with your healthcare needs. The staff at ICRM will be happy to complete forms and provide medical letters as necessary upon your request. However, because this can be time-consuming, fees for this service will apply. While these charges vary, they generally range from $50.00-$100.00 per form. Costs will be discussed in advance, and prepayment is required. Please allow 10-14 business days for completion of requested forms/letters.

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a Release of Medical Information must be completed and signed prior to receipt of these materials. Payment is required at the time of pickup/delivery. ICRM will put forth every effort to respond to these requests promptly.

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Idaho Center for Regenerative Medicine OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

_____

PRINTED NAME

_____ _____

SIGNED NAME DATE

Idaho Center for Regenerative Medicine

ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!

6001 W. State Street, Suite B, Boise, ID 83703

208-995-2802 / 208-995-2804 (fax) / www.icrmboise.com

Bio-identical Hormone Replacement Therapy is the use of human bio-identical hormones (hormones which are identical to the hormones in your body) to augment levels of these hormones in the body which decline with the aging process. The goal is to bring these hormones to more youthful and balanced levels, and thereby, improve quality of life. Medical evidence suggests that many of the consequences of aging are secondary to the declining level of these hormones and that restoring levels into a youthful range greatly improves functionality, energy and helps to alleviate signs and symptoms of age related diseases. While orthodox medicine may not officially endorse this approach, the medical literature certainly supports it with a plethora of studies and date rendering. **BHRT is medically evidence based.**

As with any therapy, there are numbers of contra-indications, cautions and caveats prior to treatment, as well as serum level determination and dosage adjustments after treatment is initiated. Your provider will work closely with you to reach the optimal level for you!

I understand the foregoing and consent to therapy.

_____ _____

NAME DATE

Idaho Center for Regenerative Medicine

ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!

6001 W. State Street, Suite B, Boise, ID 83703

208-995-2802 / 208-995-2804 (fax) / www.icrmboise.com

ACKNOWLEDGEMENT OF PRIVACY NOTICE

As of April 1, 2003, our office is implementing the requirements of the Health Insurance Portability and Accountability Act (HIPPA) which was passed by the federal legislature.

Your signature is necessary. Please review the 'Privacy Notice' and indicate that you have reviewed this document by signing below.

"My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice."

_____ _____

Print Name Date

_____

Signature

Idaho Center for Regenerative Medicine

ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!

6001 W. State Street, Suite B, Boise, ID 83703

208-995-2802 (office) / 208-995-2804 (fax) / ***www.icrmboise.com***

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient:_____ DOB: _____

Is there someone you wish to authorize us to share and/or discuss your records with? A spouse, child or relative or additional provider?
If so, complete below.

I hereby request and authorize: **ICRM, *6001 W. State Street, Suite B, Boise, ID 83703***

To Release/Receive Information to/from: _____

Relation:_____

Address:_____

City/State/Zip: _____

Information to be disclosed include copies _____ Labs _____ Chart Notes _____ Entire Record

I hereby authorize the use or release/disclosure of protected health information regarding the above-named individual as described herein. I understand that this authorization is voluntary and made at my direction with no expiration unless revoked in writing by me.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ _____

Signature of Patient *Date*