Male Weight Loss Program

Dear Patient,

Thank you for your interest in BioBalance® Health and our medicated weight loss program. Our metabolism slows as we age, primarily because we lose muscle mass and replace it with fat. This process begins when our testosterone begins to drop to a critical level and continues throughout our lives. This makes weight loss more difficult as we age. Unfortunately the loss of muscle and increase in fat causes health problems that worsen over time.

BioBalance Health, LLC offers the most comprehensive fat loss program in St. Louis and Kansas City. We combine individualized weight loss medication that increases metabolism and accelerates loss of weight, diet counseling for your blood type and genetic inheritance, review and planning of your exercise program, and the most effective hormone replacement with bio-identical testosterone pellets that increase muscle mass and decrease body fat. This program is individually designed by reviewing all of the components of your lifestyle.

The goal of our program is to speed up your metabolism, decrease hunger, and shape your body from the inside out to rebuild the body of your youth. Our "secret weapon" for weight loss is our i-Lipo Laser that melts fat away in the most important areas (waistline, back fat, and hips) while you lose total weight w th our prescription medication program. Losing weight looks the best when you can target your fat loss by using our i-Lipo Laser sculpting treatments.

Please complete, sign, and return the attached forms.

BioBalance Health
10800 Olive Blvd. Creve Coeur, MO 63141
Attn: Receptionist
Fax: (314) 218-3999
Email: newpatient@biobalancehealth.com

Once we receive your information we will contact you to schedule your initial consultation. Thank you and we look forward to seeing you soon!

Sincerely,

Kathy C. Maupin, M.D.

Rachel Maupin Sullivan, D.O.

Male New Patient Questionnaire

Patient Demographics

First Name:	Middle:	Last Name:	
Home Phone:		Cell Phone:	
SSN/Driver's License Number:			Marital Status:
Email:			Referred by:
Address:			City:
State:	Zip:	Age:	Date of Birth:
Urologist:		Primary Care Physician:	
Occupation:		Employer:	
Office you will be Visiting: ☐ St. Louis ☐ Kansas City			
May we Contact you by: ☐ Text ☐ Cell Phone ☐ Home Phone ☐ Email ☐ Office Phone			

Emergency Contact Information

Name:	Relationship:
Primary Phone:	Secondary Phone:
Email:	

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10800 Olive Blvd
Creve Coeur MO 63141

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Phone: (314) 993-0963
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Male New Patient Questionnaire

Current Medications (List all current medications)

Drug	Dose	How Often?

Supplements (List all current supplements)

Supplement	Dose	How Often?

List all Allergies and Reactions (Food, Drug, etc.)

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Male New Patient Questionnaire

History of Present Illness/Symptoms (check all that apply)

	Low or No Sex Drive (Libido)
	Fatigue or Lack of Energy
	Erectile Dysfunction (ED)
	Loss of Morning Erections
	Decreased or No Ejaculation
	Depression
	Anxiety
	Change in Mood or Irritable
	Insomnia
	Memory Loss or Foggy Thinking
	Feeling Hopeless
	Low or No Motivation
	New Migraine Headaches
	Decreased Muscle Mass & Strength
	Joint Aches/Arthritis
	Poor Balance & Coordination

	Dry Eyes
	Weight Gain
	Belly Fat
	Male Breast Development
	Ringing in Ears
	Dry Skin
	Constipation
	Thinning Eyebrows/Eyelashes
	Thinning Hair
	Cold All of The Time
	Swelling All Over Body
	Brittle Nails
	Ache All Over
	Poor Immunity
	Snoring
	Other:

Exercise History (Check all that apply)

	I don't exercise
	Normal daily activity is what I consider exercise
	I have a very physical job
	I exercise daily for 45min or more
	I exercise 3-5x/week for 45min or more
	I lift weights
	I am a long-distance runner, biker, or triathlete
	Other:

Previous Testosterone Replacement (Check all that apply)

	I Have Used Pellet T Before
	I Have Used T Gel Before
	I Have Had Testosterone Shots Before
	I Have Used Testosterone in the past
	I Have Used "Anabolic Steroids" to gain muscle. # of years ago? for how long?
	I Use or Have Used Growth Hormones
	Other:

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Male New Patient Questionnaire

Surgical History (List year of surgery)

Year	Surgery
	Gastric Bypass, Lap Band, or Other Surgery for Weight Loss
	Joint Replacement
	Open Heart Surgery or Stents
	Pacemaker
	Prostatectomy
	Vasectomy
	Other:

Family History (Check all that apply)

	Autoimmune Disease
	Blood Clots
	Breast Cancer
	Colon Cancer
	Dementia
	Diabetes, Type I
	Diabetes, Type 2
	Heart Attack or Heart Disease
	Hemochromatosis
	Obesity
	Prediabetes
	Prostate Cancer
	Stroke
	Testicular Cancer
	Thyroid Disease – high or low
	Other:

Preventative Medicine (Check all that apply)

	PCP Visit in the last year
	Urologist Visit in the last year
	Colonoscopy in the last 10 years
	Other:

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Male New Patient Questionnaire

Past Medical History (List year of Illness)

Year	Illness
	ADD or ADHD
	Addison's Disease
	Adrenal Fatigue
	Alcoholism, AA, Drug Dependence
	Arthritis
	Autoimmune Disease (Rheumatoid, Lupus, etc.)
	Blood Clot/Pulmonary Embolism
	BPH: Benign Prostatic Enlargement
	Colon Cancer
	Concussion
	Contact Sports
	Cushing's Disease
	Depression/Anxiety
	Diabetes Type I
	Diabetes Type II
	Emphysema / COPD
	Fatty Liver Disease
	Glaucoma
	Heart Arrhythmia
	Heart Attack
	Heart Murmur
	Hemochromatosis
	Hepatitis

Year	Illness
	High Blood Pressure
	High Cholesterol
	HIV or AIDS
	Hyperthyroid
	Hypothyroid
	Insulin Resistance
	Kidney Disease
	Manic Depression or Bipolar Disorder
	Multiple Sclerosis (MS)
	Mumps
	Narcolepsy
	Osteopenia or Osteoporosis
	Overweight or Obese
	Prostate Cancer
	Restless Leg Syndrome (RLS)
	Schizophrenia
	Seizures or Epilepsy
	Sleep Apnea
	Stroke
	Testicular Cancer
	Testicle Trauma (Kick, Punch, etc.)
	Tuberculosis (TB)
	Other:

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Male New Patient Questionnaire

Social History (Check all that apply)

	I am still fertile
	I have completed my family
	I am married or in a committed relationship
	I am sexually active
	I want to be sexually active
	I am heterosexual
	I am homosexual
	I am bisexual
	If you smoke how many packs/day/# of years?
	If you previously smoked, how many packs/day/# of years?
	I drink more than 10 drinks of alcohol/week
	I drink everyday
	I am a recovering alcoholic
	I use or have used marijuana in the past year
	I use or have used cocaine
	I use or have used heroin
	Other:

Diet History (Check all that apply)

	I eat anything I want
	I don't eat much and gain weight anyway
	I have gained weight in my abdomen
	I do not eat wheat (gluten sensitivity/intolerance)
	I eat a low carb diet
	I eat a low-fat diet
	I eat 3 meals a day
	I eat 6 small meals a day
	Vegan/Vegetarian
	Intermittent Fasting
	Keto Diet
	Atkins/South Beach Diet
	Weight Watchers
	Other Diet Information:
	Previous Diets Tried:

Current Weight: _____(lbs) **Current Height: _____(ft, in)** **Goal Weight: _____(lbs)**

Current Pant Size: _____ **Goal Pant Size: _____**

I attest that all the information I give is true.

Print Name: Signature: Date:

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Weight Loss Fee Schedule

Consultations (45 minutes):	$200
Follow up Consultations:	$150

*Actual cost may vary based on your individual treatment plan.

* Email will be used for most patient communication, unless otherwise discussed

Payment is due at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I understand that BioBalance® Health is **not a Medicare provider** and services provided by BioBalance® Health are not covered by Medicare.

I acknowledge that BioBalance® Health has no contracts with any insurance companies and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name: Signature: Date:

Consent to Communicate

Please indicate the ways you consent for BioBalance Health to communicate with you

	Can contact (Yes/No)	Can leave message (Yes/No)
Cell Phone		
Home Phone		
Work Phone		
Email		
Text Message		

Do we have permission to speak with spouse/partner? Yes_____ No_____

Do we have permission to leave a message with spouse/partner? Yes_____ No_____

If yes, please list name(s) and relationship _____

Print Name: Signature: Date:

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Copying and Faxing Records, Forms, Financial Summaries, etc.

BioBalance Health collects a $35 fee for all copying or faxing of records, lab results, insurance forms, and financial summaries for tax purposes.

A signed release form is required before BioBalance Health will send, fax, email, etc. any medical records or information.

We will require a credit card prior to copying or faxing any of your forms, and will charge the card immediately. The time frame for copying is two weeks. Requests from life or disability insurance companies will also be charged to you and you may request reimbursement from the company.

Print Name: Signature: Date:

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. We are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy.

I attest that all the history I give is true and I understand that this consent shall remain in force from this time forward.

Print Name: Signature: Date:

BioBalance Health – Quest Diagnostics Quest Account STL 78300024

10800 Olive Blvd - St. Louis, MO 63141 Phone (314) 993-0963 Fax (314) 218-3999

☒ Kathy C. Maupin M.D. ☒ Bill Insurance

☒ Fax Results to (314) 218-3999 ☒ Draw Before 9:00 AM ☒ FASTING

Date:_____ Name:_____

Street:_____

City:_____ State:_____ Zip:_____

Insurance Co. Name:_____ Member ID #:_____ Group #:_____

Diagnosis Codes: E29.1, E34.9, R53.83, Z00.8, E66.3

☒ **Male (20 test)**
☒ 10231 CMP
☒ 7600 Lipid Panel
☒ 6399 CBC w/Diff
☒ 10124 Cardio CRP
☒ 16293 IGF-1
☒ 4212 Cortisol AM
☒ 615 LH
☒ 470 FSH
☒ 746 Prolactin
☒ 23244 Estrone
☒ 785 ABO Group
☒ 899 TSH
☒ 866 T4 free
☒ 34429 T3 free
☒ 5363 PSA
☒ 36170 Testosterone (free & Total)
☒ 457 Ferritin
☒ 496 Hemoglobin A1C
☒ 561 Insulin (fasting)
☒ 31789 Homocysteine

Ver 3.0 May 2018 **Signature:** Kathy C Maupin **Total Test Ordered: 20**

BioBalance Health – LabCorp LabCorp Account STL 24863400

10800 Olive Blvd - St. Louis, MO 63141 Phone (314) 993-0963 Fax (314) 218-3999

☒ Kathy C. Maupin M.D. ☒ Bill Insurance

☒ Fax Results to (314) 218-3999 ☒ Draw Before 9:00 AM ☒ FASTING

Date:_____ Name:_____

Street:_____

City:_____ State:_____ Zip:_____

Insurance Co. Name:_____ Member ID #:_____ Group #:_____

Diagnosis Codes: E29.1, E34.9, R53.83, Z00.8, E66.3

☒**Male (20 test)**
☒322000 CMP
☒303756 Lipid Panel
☒005009 CBC w/Diff
☒120766 Cardio CRP
☒010363 IGF-1
☒104018 Cortisol AM
☒004283 LH
☒004309 FSH
☒004465 Prolactin
☒004564 Estrone
☒006056 ABO Group
☒004259 TSH
☒001974 T4 free
☒010389 T3 free
☒010322 PSA
☒070195 Testosterone, Free & Total
☒004598 Ferritin
☒001453 Hemoglobin A1C
☒004333 Insulin (fasting)
☒706994 Homocysteine

Signature: Kathy C Maupin **Total Test Ordered: 20**

BioBalance Health – Lab Rec

10800 Olive Blvd - St. Louis, MO 63141 Phone (314) 993-0963 Fax (314) 218-3999

☒ Kathy C. Maupin M.D. ☒ Bill Insurance

☒ Fax Results to (314) 218-3999 ☒ Draw Before 9:00 AM ☒ FASTING

Date:_____ Name:_____

Street:_____

City:_____ State:_____ Zip:_____

Insurance Co. Name:_____ Member ID #:_____ Group #:_____

Diagnosis Codes: E29.1, E34.9, R53.83, Z00.8, E66.3

☒**Male (20 test)**
☒CMP
☒Lipid Panel
☒CBC w/Diff
☒Cardio CRP
☒IGF-1
☒Cortisol AM
☒LH
☒FSH
☒Prolactin
☒Estrone
☒ABO Group
☒TSH
☒T4 free
☒T3 free
☒PSA
☒Testosterone (free & Total)
☒Ferritin
☒Hemoglobin A1C
☒Insulin (fasting)
☒Homocysteine

 Signature: _____ **Total Test Ordered: __20___**