BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

NEW PATIENT HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (Last, First): _____ **DOB:** _____

Marital Status: _____

Contact Phone: _____

Address: _____

Email: _____ **Occupation:** _____

Preferred Pharmacy: _____ **Primary Care Provider:** _____

Notice of Patient Privacy/ Patient Consent Form

I understand that as part of my healthcare, the providers at Bloom Wellness Clinics, originate and maintain health records describing my health histroy, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill services provided to me, to communicate with oter healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Bloom Wellness Cinics' Notice of Privacy Practices provides specific inofrmation and complete description of how my personal information may be used and disclosed. I understand that a copy of the notice of privacy practices is available at the front desk and understand that I have the right to review the notice prior to signing ths consent. I understand that Bloom Wellness Clinic reserve the right ot change the Notice of Privacy Practices prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be given to, or mailed to me if I request below. I undertand I have the right to restrict the use and/or disclossure of my personal health information treatment , payment, or healthcare operations and tha Bloom Wellness is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Bloom Wellness has already taken action in reliance on y prior conset. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintan. If or when we change our notice, we will post the new motice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to coomunicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

NOTE: Bloom Wellness must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want to authorize disclosure to third-person/parties, please indicate as much on the relevant authorization form.

_____ _____

Patient Signature Date

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed:

_____

_____

_____

Surgeries/Hospitalizations (Year & Reason):

_____

_____

_____

Prior Hormone Treatments:
Year/Type/Duration/Issues

_____

_____

List your prescribed drugs and over-the counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications:

Name the Drug:	Reaction You Had:

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHO MAY WE CONTACT FOR YOU?

Name: _____

Cell Phone: _____

Work Phone: _____

This Person's relation to you: _____

BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

WOMEN ONLY

Age at onset of menstruation: _____
Date of last menstruation: _____
Period every _____ days:
Are you sexually active? (Men/Women/Both): _____
If not trying for a pregnancy list contraceptive or barrier method used: _____
Any discomfort with intercourse? _____
Heavy periods, irregularity, spotting, pain, or discharge: _____
Number of pregancies _____ Number of live births _____
Date of last pap & where: _____
Date of last colonoscopy: _____
Date of last Mammogram: _____
Date of last Bone Density: _____
Are you pregnant or brestfeeding: _____

MEN ONLY

Do you usually get up to urinate during the night? _____
If yes, # of times: _____
Do you feel pain or buring with urination: _____
Any blood in urine? _____
Do you feel burning discharge from penis? _____
Has the force of your urination decreased? _____
Any difficulty with erecetion or ejaculation? _____
Are you sexually active? (Men/Women/Both): _____
Any testicle pain of swelling? _____
Date of last Prostate and rectal exam? _____
Date of last colonoscopy? _____
Date of last Bone Density? _____

OTHER SYMPTOMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ No Symptoms	☐ Itchy Skin	WOMEN ONLY:
☐ Hot Flashes	☐ Mood Swings	☐ Vaginal Dryness
☐ Difficulty Sleeping	☐ Joint Pain	☐ Painful Intercourse
☐ Weight Gain	☐ Fatigued	☐ Vaginal Dryness
☐ Frequent Urination	☐ Brain Fog	☐ Irregular Menses
☐ Hair Thinning	☐ Constipation/Diarrhea	☐ Excess Facial Hair
☐ Loss of Muscle Mass	☐ Weight Loss	☐ Heavy Menses
☐ Low Libido	☐ Acne	MEN ONLY:
☐ Numbness/Tingling	☐ Heat/Cold Intolerance	☐ Erectile Dysfunction
☐ Bloating/Digestive Issues	☐ Headaches	☐ Enlarged Male Breast Tissue

BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise) ☐ Mild (i.e, climb, stairs, walk3 block, golf ☐ Occasional Vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular vigorous exercise (i.e, work, or recreation 4x/week for 30 minutes)		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you experienced Blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes- pks. /Day	☐ Chew #/day	☐ Pipe #/day ☐ Cigars #/day
	☐ # Of years		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIGICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**		
Mother					
Sibling					
			Grandmother Maternal		
			Grandfather Maternal		
			Grandmother Paternal		
			Grandmother Paternal		

BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

NO SHOW AND CANCELLATION POLICY

To provide effective and efficient treatment to all our patients, it is the policy of this office that all appointment cancellations are made **at least 24 hours prior** to your scheduled appointment time. If you are unable to keep your appointment, please call our office at **480-707-9050** to reschedule.

If an appointment is not cancelled or patient fails to show up for appointment, Bloom Wellness Clinics, LLC reserves the right to charge patient a **$50 fee** per occurrence to the credit card listed below. As this fee is not billed to any insurance company, patient accepts full responsibility to pay this fee.

CREDIT CARD INFORMATION

Number: _____ Exp: (mm/yy) _____ CVV: _____

Cardholder Signature X _____ Date: _____

☐ Keep card on file for future consultations and/or purchases.

I have carefully read, understand, and agree to comply with the above Office Policy.

_____

Patient Signature Date

BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

PATIENT FINANCIAL RESPONSIBILITY INFORMATION FORM

Dear Patient:

First, thank you for making the financial commitment to your health. This is a statement of our financial policies:

1) NO INSURANCE: As you may already know, Bloom Wellness Clinic ("Bloom") does **NOT** accept insurance. **However,** Bloom has priced office visits to correspond with what you may otherwise have to pay in co-pays with insurance and the typical treatments not otherwise covered by insurance are also competitively priced, which is designed to minimize the difference between what you would pay with insurance versus without. Treatments are NOT covered by insurance but are priced to be aggressively competitive with similar treatments available elsewhere.

2) LAB COSTS: Labs ordered by Bloom may be covered by your insurance, although Bloom makes no guarantees with regards to your insurance coverage for labs and you are solely responsible for checking with your insurance and paying for lab fees, as those are provided by third-parties.

3) PRESCRIPTIONS: In some instances, prescription drugs may be covered by your insurance. Bloom encourages you to seek coverage for prescriptions, but cannot make any guarantees that insurance will cover such medicines.

4) PATIENT FINANCIAL RESPONSIBILITIES: You understand that you are obligated to ensure that Bloom's fees are paid in full at the time of service, via cash, check, or credit. The Patient is ultimately responsible for payment of the bill, regardless of who contributes to such costs. Bloom does not accept insurance, and many insurance companies have additional requirements or stipulations that may affect your coverage for things like labs and prescriptions. Thus, you agree by your signature below that you will be responsible for any amounts due to third parties that are not covered or payable by your insurance. Bloom reserves the right to deny treatment to any person who does not pay in advance of receiving such treatments. If you pay by check, you agree to be responsible for any costs of collection resulting from returned check payments.

ACKNOWLEDGEMENT: I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance:

_____ _____

Print/Patient Name Date of Birth

_____ _____

Signature (note if signing as an authorized representative) Date of Signing

BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

9755 N. 90th St., Scottsdale, AZ 85258// (480) 707-9050// info@azbloomwellness.com

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended testing, examination and treatment procedures to be used so you can make an informed decision about proceeding. This consent form is to confirm that you understand the risks, that you understand you can and should ask questions and that you have a right to have answers to questions regarding any suggested testing or treatment. You understand that NO GUARANTEES ARE MADE with regards to any treatment you may receive, and by signing hereto, you are acknowledging that you understand that ALL MEDICAL TREATMENTS can carry risks, known and unknown, at the time they are provided. Each person is different, and you may have sensitivities, allergies, or side effects unique to your body. You must notify your provider if you are aware of any prior issues with *any* medical treatments.

This consent provides Bloom Wellness Clinics ("Bloom") with your permission to perform reasonable elective or necessary diagnostic tests, examinations, procedures, or treatments. By signing below, you are acknowledging that you (1) intend this consent to be continuing in nature even after any initial diagnosis or treatment and (2) you consent to treatment at this Bloom office or any other Bloom office under common ownership. This consent will remain in effect until it is revoked in writing. You have the right to discontinue services and treatment at any time, however, you understand that doing so may be against medical advice.

You have the right to, and Bloom encourages you to, discuss any treatment plan with your Bloom Provider and to ask about the purposes, potential risks and benefits of any test or treatment. Certain risks, such as a allergic reactions, infections, side effects and/or adverse drug reactions are always possible with certain types of medical tests and/or treatments, and you should always watch for signs or symptoms and should call 911 or go to an emergency room if you experience serious symptoms following any test or treatment.

By signing below, I am voluntarily, freely and without duress, requesting that a Bloom healthcare provider and/or authorized designees on their behalf, perform the suggested examinations, testing and treatments for the conditions that have brought me to the Bloom clinic. I understand that if additional testing, procedures or treatment are recommended, I may be asked to read and sign additional consent forms prior to the test, procedure or treatment. I also understand that third party providers, such as laboratories and others to whom I may be referred may have their own consent forms for me to sign before I can receive their services. I understand that while Bloom may offer me a referral to a specialist or general practitioner for services outside of Bloom's practice area, Bloom makes NO GUARANTEES regarding any outcomes related to those referrals, and each patient is solely responsible for their treatment and payment to any third-parties not employed or contracted with Bloom. I UNDERSTAND THAT ALL MEDICAL PROCEDURES AND TESTS MAY HAVE INHERENT RISKS, such as allergic reactions, side effects, and infection and these risks can result in serious injury or even death. I acknowledge that I have been warned via this document about the possibility of such risks. I hereby certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents:

Signature	Patient Date of Birth
Print Name	Date Signed

BLOOM WELLNESS
BLOOM WELLNESS CLINICS LLC

9755 N. 90th St., Ste. B295, Scottsdale, AZ 85258// (480) 707 9050 // info@azbloomwellness.com

BLOOM WELLNESS PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT TO RELEASE OF INFORMATION FORM

This form is your opportunity to learn about and consent to how your medical information is used. If you disagree with any terms herein, you are not obligated to accept the terms and corresponding treatment and Bloom Wellness Clinic (hereinafter "Bloom") is not obligated to provide treatment if terms cannot be agreed upon. Please read carefully and feel free to ask your provider if you have any questions.

Please print and provide the following patient information:

Last Name:	MI:	First Name:	Date of Birth:
If Authorized Representative:			

1) _____ (Patient/Representative's Initials): **HIPAA Notice of Privacy Practices:** By initialing herein, I acknowledge that I have been provided the opportunity to receive and review Bloom's Notice of Privacy Practices, which describes how Bloom may use and disclose my healthcare information, including protected healthcare information as contemplated by the Health Insurance Portability and Accountability Act of 1996, aka "HIPAA" laws. I authorize Bloom to use such information for; determining and providing my treatment, for recording and collecting payment, for Bloom's healthcare operations, and for other described and permitted uses and disclosures. I understand that if I have a question or concern, I can contact Bloom's Privacy Officer through the phone number listed on the top of this form as well as by email inquiry to info@azbloomwellness.com. I understand and authorize such information to be disclosed electronically to Bloom and its authorized Providers, management and business associates who have a need to know such information for the purposes described herein. To the extent permitted by law, I authorize and consent to the use and disclosure of my information for the purposes described herein.

2) **Communication about my Healthcare:** By my signature below, I agree that my Bloom Provider or an agent acting on behalf of my Bloom provider may contact me for the purpose of scheduling appointments, relaying test results, or otherwise discussing my health information.

3) **Consent for Security Recording and Authorized Photography:** I consent to photographs, digital or audio recordings or images being recorded for security purposes and/or the clinic's health care operations purposes. I understand that Bloom retains the ownership rights to the images or recordings. I understand that these images will be securely stored and protected. Images or recordings in which I am specifically identified will not be released and/or used outside of legitimate business purposes without specific written authorization from me or my legal representative unless otherwise permitted or required by law. Bloom DOES NOT take video, photo, or audio recordings of patient's treatments or procedures unless specifically requested or authorized in writing by the patient. Bloom DOES record public spaces in BLOOM

facilities and non-patient treatment rooms for security and operational reasons due to the controlled nature of certain products that may be on the premises.

3) **Consent to Receive Electronic/Digital Communications:** If ay any time I provide an email address or cell phone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare information at the email or text address I have provided to Bloom or its authorized agents. Information received may include, but is not limited to, treatment instructions, educational information, prescription information, and test or lab results. Such information may be provided to family or designated representatives that you have authorized Bloom to communicate with in writing. **If you wish to limit or cancel such authorizations, you must do so in writing to Bloom.** Information will continue to be provided in the selected method until such time as Bloom has reasonably been able to confirm receipt of, and implement, the written request to stop. Bloom does not charge for such communications, but standard text messaging and cellular rates may apply.

4) **Use of Electronic Health Records:** Bloom uses Electronic Health Records to store patient information. These records may include demographic information, financial information, and health information. This information will be updated as appropriate and shared between our affiliated clinics when necessary for operational or diagnostic/treatment reasons. This information will not be shared with unauthorized third-parties such as advertisers without your written consent.

5) **Release of Information/Disclosures to Family or Friends:**

I hereby designate the following individuals to receive protected health care information and to discuss such information with my BLOOM health care provider:

Last Name:	First Name:	Phone #/Contact:
Last Name:		

By my signature hereto, I hereby permit Bloom and its authorized representatives to release healthcare information for purposes of treatment, payment, or healthcare operations as detailed in the Notice of Privacy Practices document that has been offered to me for my review.

_____ _____

Print/Patient Name Date of Birth

_____ _____

Signature (note if signing as an authorized representative) Date of Signing