Regional Pain Care Center

Name:

____
Last First MI

Address:

____
City State Zip

Home#: _______________________ Work#:_______________________

Cell#: _________________________

DOB: _____/_____/_____ SS#: _________________

Marital Status: S / M / D / W Male/Female (circle)

Emergency Contact:

____
Name Number Relation to Patient

Referring Physician:

____
Name Number

____ _____________________
Signature: Date:

Jerry T. Holubec, D.O., P.A.

I request and consent to the administration of hormones and oral supplements. I understand and authorize that these will be prescribed by Jerry T. Holubec, D.O. I acknowledge that there are no guarantees or assurances made with respect to the benefits of hormone supplementation therapy for me.

I understand that I will be in charge of injecting/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with request for ongoing testing to assure proper monitoring of my homes levels. I agree to report to the physicians any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and compilations if I do not comply with the recommended dosage.

I have not been, promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I have been informed, that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services, including laboratory and pharmacy charges, and myself with the understanding that I will not be reimbursed by my insurance company.

I have read and understood all the above information. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to the treatment using hormone supplementation therapy.

Patient Signature: ____________________________________ Date: _________________

Physician Signature: __________________________________ Date: __________________

Jerry Holubec, D.O., P.A.

Chief Complaint/Reason for Visit: ____

Do you currently have or do you have a history of any of the following:

__ High blood Pressure
__ Heart disease
__ Angina
__Chest Pain
__Irregular heartbeat
__ Rheumatic fever
__ Mitral Valve Prolapse
__ Stroke
__ Easy bruising
__ Hemophilia
__ Bleeding tendency
__ Arthritis
__ Anemia
__ Neck Pain/stiffness
__ Spinal Cord Stimulator

__ Thyroid disease
__ Mental illness
__ Migraine Headaches
__ Fainting
__ Seizure disorder
__ Blood transfusion
__ Leg cramps/pain
__ Varicose vein
__ Chemical Dependency
__ Diabetes
__ HIV
__ Liver Disease
__ Cataracts
__ Multiple Sclerosis
__ Pacemaker

__Hepatitis
__ Vision Disorder
__ Jaundice
__ Back Injury
__ Neck injury
__ Herniated Disc
__ Steroid use
__ Ulcer
__ Frequent Heartburn
__ Hiatal Hernia
__Cancer
__ Chemotherapy
__ Glaucoma
__ TB

__ Sinusitis
__ Bronchitis
__Shortness of breath
__ False teeth/caps
__ Hoarseness
__ Recent Cold
__ Asthma
__ Motion Sickness
__ Loose teeth
__ Sexual transmitted Disease
__ Emphysema
__ Chronic cough
__ TMJ

List any medical problems not listed above:
____
____

___ Tobacco Amount: ___ packs/day for ___ years
___ Alcohol Amount: ______________________________
___ Street/Recreational Drugs: Types:_________________

List previous surgeries:

____
____

Current Medications:

Name:	Dose:	Schedule:	When last taken

Drug Allergies:

____ ____
____ ____
____ ____

____ No Known Drug Allergies

Patient Signature:____ Date: ____________________________

MEDICATION LIST

Patient Name: ________________________________ Doctor you are seeing: _____________________

Have you had any imaging studies done since last office visit? Yes or No

Date of last injection: _________________ Do you have new insurance? ______________________

Email: ____

DID YOU BRING YOUR MEDICATION BOTTLES WITH REMAINING PILLS?

List of Medications (include over the counter) Dosage Times per day

____

____

____

____

____

____

____

On the average, how severe has your pain been during the last week?

0 1 2 3 4 5 6 7 8 9 10

Not severe at all Extremely severe

In general how much is your pain interfering with day-to-day activities?

0 1 2 3 4 5 6 7 8 9 10

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be used in place of the original. I understand *I am financially responsible* to the center for charges not covered or denied by my insurance company. I further agree in the event of non-payment, to pay the cost of collection and/or court costs and reasonable fees, should this be required.

Signature: ____ Date: __________________________

Regional Pain Care Center

Human Growth Hormone Consent

I, the undersigned, request from Jerry Holubec, D.O. to be prescribed Human Growth Hormone.

*** I understand that this prescription is elective and is not medically necessary. I request Human Growth Hormone for symptomatic improvement and not to treat a medical deficiency.

*** I understand that Human Growth Hormone is not specifically FDA approved for preventive medicine and therefore my request is an off-label use of Human Growth Hormone.

*** I understand that the adult application of Human Growth Hormone has been utilized for less than ten years and its long-term effects are undetermined.

*** I certify that I have read the above consent and fully understand it. I believe I have adequate knowledge upon which to base an informed consent. I fully understand what I am signing and herby request and consent to the treatment using Human Growth Hormone.

Patient Signature: ______________________________ Date: _________________

Physician Signature: ____________________________ Date: _________________

HCG Medical History

Name: ____

Address: ____

City: ________________________________ State: _______________ Zip: ___________________

Date of Birth: _____________________________________ Male / Female (circle one)

Home Phone: ______________________________Cell Phone: ____________________________

How did you hear about us? ____

E-Mail address: ____

Reason for today's visit: ____

Current weight: _________________________ Total weight loss desired: ___________________

Do you have any known allergies: ____

Medication list (prescription/over the counter, oral and topical)

____

____

Past/Present medical conditions or surgeries:

____

____

Initial:

_________ I authorize the use of any photographs taken before or after my treatment, for teaching and other medical viewing purposes, with the understanding that I will not be identified.

To the best of my knowledge, the information I provided is true. I understand that this information is confidential and will not be disclosed without my written consent.

Patient Signature: ______________________________________ Date: _____________________

_________ Reviewed medical history.

Review and Sign

All information that we give to you regarding the HCG diet is received from sources believed to be accurate, but no guarantee can be made.

Clients are encouraged to verify for themselves, and to their own satisfaction, the accuracy of all information, recommendations, conclusions, comments, opinions, or anything else before making any kinds of decisions based upon what they have read herein.

Please note: the law requires this statement to be posted.

The FDA has not approved HCG for weight loss and there is no substantial evidence that HCG is effective in the treatment of obesity.

We do, of course, respectfully disagree with the FDA.

Signature: ___________________________ Date: _______________

Print Name: ____

Witness: ____