Steven A. Fein, MD, FACG
Chrislyn Chaloupka, FNP-C
6243 Fairmont Parkway, Suite 203B
Pasadena, Texas 77505
Office (281) 487-0812 • Fax (713) 946-7210
Email: info@letsjustimagineMD.com
www.letsjustimagineMD.com

PATIENT INFORMATION – ***Please Print*** How did you hear about us? ____________________________________

Last Name _________________________ First Name _______________________ MI ________ Date of Birth _____/_____/______

Address ____

Primary Phone# ____________________ Cell Phone# ______________________ Email ____________________________________

____ Male ____Female (Check One) ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Life-Partner (Check One)

Social Security# __________-__________-__________ Driver's License# ___________________________________ State _______

Race *(circle one)* Caucasian Black Hispanic Native American Asian Pacific American Pacific Islander Subcontinent Asian American American Indian or Alaskan Native Native Hawaiian Black Non-Hispanic White Non-Hispanic Other Race

Ethnicity *(circle one)* Latino/Hispanic Other Not Reported/Refused Desired Weight: __________ Current Weight: __________

Employer____

Emergency Contact: ______________________________Relationship: ____________ Phone Number ________________________

Nearest Relative (not living with you)

____
Name Address & Phone Number Relationship

Primary Care Doctor: ____

Referring Provider:____
Name Phone Number

COMMUNICATION AUTHORIZATION – ***Please Complete***

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact should we need to reach you. Place a √ in the appropriate box(es).

☐ Primary Phone# ☐ Message to return call ☐ Detailed message (results, treatment) ☐ No message ☐ Voice mail ☐ Family member

☐ Alternate Phone# ☐ Message to return call ☐ Detailed message (results, treatment) ☐ No message ☐ Voice mail ☐ Family member

RELEASE OF INFORMATION POLICY – ***Please Read***

I hereby authorize Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C to use and/or disclose my personal health information which identifies me, or which can be reasonably used to identify me, to carry out my treatment, payment and other health care operations. My protected health information may be released to the following individual(s):

Name ____ DOB ____/____/_____ Relationship to patient______________________

Name ____ DOB ____/____/_____ Relationship to patient______________________

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM ______ Please initial

I have been provided the Notice of Privacy Policies for Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and other health care operations. I understand that I have the right to review such "notice" prior to signing this consent.

- I understand that I may revoke this consent at any time by notifying Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C in writing, but if I revoke my consent, such revocation will not affect any actions that Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C took before receiving my revocation.
- I understand that Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C has reserved the right to change its privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or other health care operations. I understand Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C does not have to agree to such restrictions, but that once restrictions are agreed to; Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C must adhere to such restrictions.

FINANCIAL POLICY – *Please Read* ______ Please initial

- This is a financial policy agreement between Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C as creditor and the Patient/Debtor named on this form. In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "ours" refer to Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C.
- By executing this financial policy agreement, you are agreeing to pay for all services that are received.

ACKNOWLEDGEMENT – *Signature Required*

- I acknowledge that I have received the "Notice of Privacy Policies" for Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C.
- I hereby authorize Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C to release any information requested by the above-named insurance company or companies or their respective representatives for payment of services rendered.
- I understand that I am financially responsible to the physician for any charges incurred by myself and/or my dependents.
- I acknowledge full financial responsibility for services rendered by Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C, and authorize transfer of all unpaid amounts to me**.** I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default of payment of charges that are my financial responsibility.

I have read and understand the "Release of Information Policy", "Assignment of Benefits", "Notice of Privacy Policies" and the "Financial Policy" established by Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C. I further acknowledge that I accept the terms outlined in each of the policies. I understand that, while this consent is voluntary, if I refuse to sign this consent, Steven A. Fein, MD and/or Chrislyn Chaloupka, FNP-C, can refuse to treat me.

____ ______________________________

Signature of Patient (or Patient's Representative) **Date**

____

Printed Name of Patient (or Patient's Representative)

____

Representative's Relationship to Patient (if applicable)

Initial Questionnaire

Patient Name:________________________________ Date:____________________ Treatment #______________

Procedure:

Primary Goal: **Erectile Performance** **ED** **Peyronie's**

Medical History: Diabetes mellitus Hypertension Cardiovascular disease

Current Med Use: **Beta-Blockers** **SSRIs** **PDE5i [Cialis, Viagra]**

Prior use of PDE5i: **(circle one)** **YES** **NO** PDE5i Response: **None / Poor / Good**

<u>The Erectile Hardness Score [*choose one*]</u>

1. Penis is larger, but not hard
2. Penis is hard, but not hard enough for penetration
3. Penis is hard enough for penetration, but not completely hard
4. Penis is completely hard and fully rigid

SHIM

1. How would you rate your confidence that you can get and keep an erection?

1=very low 2=low 3=moderate 4=high 5=very high

2. When you have erections with sexual stimulation, how often are your erections hard enough for penetration?

1=never 2=a few times 3=sometimes 4=most times 5=always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?

1=never 2=a few times 3=sometimes 4=most times 5=always

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse?

1=extremely difficult 2=very difficult 3=difficult 4=slightly difficult 5=not difficult

5. When you attempt sexual intercourse, how often is it satisfactory for you?

1=never 2=a few times 3=sometimes 4=most times 5=always

For office use only

__________/___________ **Erectile Hardness Score** ___________ **SHIM Total Score** _____________

1-7 Severe ED 8-11 Moderate ED 12-16 Mild Moderate ED 17-21 Mild ED 22-25 No ED

____

Steven A. Fein, MD, FACG

Revd. 01/17/2020

Medical History

Patient Name: ____

Date:________________________

Age:________ DOB:____________ Height:____________ Weight:____________________

List any ED medications you are currently taking or have used in the past: ____

Did they work? Yes No Other: ____

List any conditions/medical history you currently have or have had in the past:

List any known allergies: ____

When was the last time you saw a doctor for a physical exam? ____

List all medications and supplements you are currently taking:

Medications	Supplements

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:____________________________ Date:________________

Patient Consent For GainsWave® Therapy

This document is intended to serve as confirmation of informed consent for GAINSWave® Therapy, also known as Extracorporeal Shock Wave Therapy (ESWT), as ordered by your medical practitioner (Practitioner).

A. PURPOSE

ESWT therapy is a non-invasive technique that uses pulsatile waves to stimulate blood flow to the applied area. ESWT is a safe procedure and has been used for a variety of health conditions.

When a medical device is approved for use by the Food and Drug Administration (FDA), the device manufacturer produces a "label" to explain its use. Once a device is approved by the FDA, physicians may use it "**off-label**" for other purposes if they are well-informed about the device, base its use on firm scientific method and sound medical evidence, and maintain records of its use and effects.

The ESWT device used in the therapy is cleared by the FDA for intended use as a treatment for minor aches and pains and for the temporary increase in local blood circulation.

The ESWT device is being used in the therapy as an "off-label" use. This usage is based upon scientifically designed, international clinical studies that have shown ESWT to be effective in optimizing sexual health and wellness, including erectile dysfunction.

B: BENEFITS

Scientific studies have shown that when applied to an area, ESWT increases blood flow, by stimulating the growth of new blood vessels (neovascularization) and growth factors thus enhancing tissue growth and repair.

C. CONSENT FOR PROCEDURE

I have received either written or verbal information about my condition, the proposed treatment, alternatives, and related risks. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. This form contains a brief summary of this information.

I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests and where delay might impair my health.

1. I authorize Practitioner to treat my condition, including performing further diagnosis, the therapy procedures described below, and such photographs as may be recommended for medical records only.

2. I understand the purpose of the therapy procedure(s) to be: apply Extracorporeal Shock Wave Therapy with an FDA cleared medical device to those areas that the Practitioners believes will be most effective in optimizing sexual health.

3. Although ESWT has been performed on thousands of patients and the risks are very low, we must

list them. I understand the most common risks associated with the proposed procedure(s) to be: swelling, reddening of skin, soreness. Less common risks to the proposed procedure(s) to be: hematoma (bruising), petechiae (minor broken blood vessels).

4. I also understand that there may be other RISKS OR COMPLICATIONS, OR SERIOUS INJURY from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

5. By initiating a course ESWT, Practitioner is using his or her best judgment in recommendations for you and there is no guarantee of an outcome.

6. I understand that if I did not wish to accept the risks associated with this therapy then I would choose to not sign this consent.

7. I have informed the Practitioner of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the Practitioner of all current medications and supplements I am taking.

D. CONSENT FOR LOCAL ANESTHESIA

When local anesthesia and/or sedation is used by the practitioner. I consent to the administration of such local anesthetics as may be considered necessary by the practitioner in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures from lidocaine.

E. PATIENT CERTIFICATION

By signing below, I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.

______________________________ /______________________ SIGNATURE OF PATIENT and DATE