CANCELATION - NO-SHOW AGREEMENT

Patient's
Name:_____

I agree to call the office at least 24 hours prior to my appointment time if I need to cancel my appointment (we understand that emergencies can arise inside of a 24 hour time frame). _____(initials)

A $100.00 Fee will be billed to your account or charged to your credit card for any No Show or Non-Emergency cancellations within 24 hours.

Patient
Signature:_____

Today's Date :_____

Today's Date: _____

Annual Exam

Patient Name : _____ Date Of Birth:_____ Email:_____

Address: _____

Phone :_____ Primary Care Physician:_____

Allergies:_____

Tobacco Use: NO / YES_____ Alcohol: NO / YES_____ drinks per week

Last Menstrual Period:_____ Contraception: NO /YES_____

Medications:_____

_____

Supplements:_____

Pharmacy:_____

General		**Gastrointestinal**		**Respiratory**	
Sweats	Yes / No	Nausea	Yes / No	Cough	Yes / No
Anorexia	Yes / No	Vomiting	Yes / No	Wheezin	Yes / No
Fatigue	Yes / No	Diarrhea	Yes / No	Shortness of breath	Yes / No
Weight Loss	Yes / No	Changes in bowel habits	Yes / No	Cardiovascular	Yes / No
Weight Gain	Yes / No	Abdominal Pain	Yes / No	Chest Pains	Yes / No
Insomnia	Yes / No	Change in appetite	Yes / No	Palpitations	Yes / No
Anxiety	Yes / No			**Gyn**	
Depression	Yes / No			Bladder concerns	Yes / No
Skin		**Breast**		Urinary leakage	Yes / No
Bruising	Yes / No	Pain	Yes / No	Spotting between periods	Yes / No
Rash	Yes / No	Lump	Yes / No	Vaginal discharge	Yes / No
Suspicious lesions	Yes / No	Discharge	Yes / No	Pain with intercourse	Yes / No
				Unusual pelvic pain	Yes / No

Date and location of last: Mammogram:_____ **Bone Density:**_____ **Colonoscopy:**_____

I would like to make an appointment to discuss concerns I have with: (please circle your concerns) Anti-Aging

Mood Issues Fatigue Hormones Sex Drive Sleep

Supplement Weight Other:_____

Keep in mind, Dr. Jill has a limited amount of time at your annual visit. To keep her schedule moving, she does not have the ability to completely discuss concerns outside the scope of your annual wellness visit. An additional appointment may be necessary to give you the best treatment option.

RENEU HEALTH & MEDISPA

SYMPTOM CHECKLIST - WOMEN

Patients Name:_____

Todays Date: _____

The following checklist can help identify symptoms of hormone imbalance and help you select the most appropriate ZRT test profile. Mark the signs and symptoms that are present, problematic, or persist over time.

CATEGORY 1 | SEX HORMONE IMBALANCE* - **Recommended:** Saliva Profile I

- ☐ Acne
- ☐ Bone loss
- ☐ Cystic ovaries (PCOS)
- ☐ Depressed mood
- ☐ Fibrocystic breasts
- ☐ Foggy thinking
- ☐ Headaches
- ☐ Heart palpitations
- ☐ Heavy menses
- ☐ Hot flashes
- ☐ Increased body/facial hair
- ☐ Irritability
- ☐ Low libido/decreased sexual function
- ☐ Mood swings (PMS)
- ☐ Night sweats
- ☐ Urinary incontinence
- ☐ Uterine fibroids
- ☐ Vaginal dryness
- ☐ Weight gain

CATEGORY 2 | ADRENAL HORMONE IMBALANCE - **Recommended:** Adrenal Stress Profile or Cortisol Awakening Response Profile

- ☐ Aches and pains
- ☐ Afternoon/evening fatigue
- ☐ Allergies
- ☐ Anxiety
- ☐ Autoimmune diseases
- ☐ Bone loss
- ☐ Chronic health problems
- ☐ Depression
- ☐ Diabetes/prediabetes
- ☐ History of steroid usage
- ☐ Low blood sugar
- ☐ Morning fatigue
- ☐ Salt/sugar cravings
- ☐ Sleep disturbances
- ☐ Susceptibility to infections
- ☐ Weight gain

CATEGORY 3 | THYROID HORMONE IMBALANCE - **Recommended:** Comprehensive Thyroid Profile

- ☐ Aches and pains
- ☐ Anxiety
- ☐ Brittle nails
- ☐ Cold hands and feet
- ☐ Constipation
- ☐ Depression
- ☐ Dry skin
- ☐ Elevated cholesterol
- ☐ Fatigue
- ☐ Feeling cold all the time
- ☐ Foggy thinking
- ☐ Headaches
- ☐ Heart palpitations
- ☐ Inability to lose weight
- ☐ Infertility
- ☐ Low libido
- ☐ Menstrual irregularities
- ☐ Sleep disturbances
- ☐ Thinning hair
- ☐ Weight gain

CATEGORY 4 | METABOLIC IMBALANCE - **Recommended:** Weight Management Profile + Thyroid + Cardio

- ☐ Diabetes (or family history)
- ☐ Elevated cholesterol
- ☐ Fatigue
- ☐ Gestational diabetes (or family history)
- ☐ Heart disease/stroke (or family history)
- ☐ High blood pressure
- ☐ High blood sugar
- ☐ Insulin resistance
- ☐ Low physical activity
- ☐ Low thyroid/decreased sexual function
- ☐ PCOS
- ☐ Salt/sugar cravings
- ☐ Smoking (or history of)
- ☐ Thyroid disorders
- ☐ Weight gain

CATEGORY 5 | NEUROTRANSMITTER IMBALANCE - **Recommended:** NeuroAdvanced Profile

- ☐ ADD/ADHD
- ☐ Addictive behaviors
- ☐ Anxious/nervous
- ☐ Autism spectrum disorder
- ☐ Depressed
- ☐ Developmental delays
- ☐ Eating disorders
- ☐ Irritable
- ☐ Methylation deficits
- ☐ Mood swings
- ☐ OCD
- ☐ Panic attacks
- ☐ PMDD (Premenstrual Dysphoric Disorder)
- ☐ Sleep disturbed
- ☐ Tearful

Reneu Health & Medispa
W359 N5009 Brown St., Suite 208 Oconomowoc

Office of Dr. Jill Wohlfeil
262-560-1920

Patient's Name: _____ Date: _____ Amount Paid: _____

CPT CODES:

Estradiol - 82670
FSH – 83001
LH – 83002
Progesterone – 84144
Testosterone – 84402

T3 Free – 84481
T4 – 84436
TSH – 84443

Glucose – 82947
HGB – 85018
Lipid – 80061
Vit. D – 82306

B12 – 82607
Calcium – 82310
Cortisol AM – 82530
DHEAS – 82627
HgbA1C – 83036
Insulin – 83527

ANA Titer – 86039
Candida Antibodies – 86628
CBC – 85027
CMP – 80053
CRP – 86140
Ferritin – 82728
Homocysteine – 83090
Iodine – 83789
Magnesium – 83735
R-T3 - 84482
Sedrate – 85652
Thyroid Antibodies – 86376
TIBC – 83550
Trans Ferrin – 84466
CA125 - 86304

ICD 10 CODES:

Acne - L70.9
Anemia: D50
Anxiety: -F41.9
Amenorrhea – N91.2
Breast Pain - N64.3
Decreased Libido: R68.82
Endometriosis – N80.9
Family History of Ovarian Cancer: - Z80.43
Fatigue – R53.83
Fibroid, Uterus – D25.9
Hair Loss: I 65.9
Headaches: - R51
Hot Flashes – N95.1
Hypothyroid: - E03.9
Insomnia – G47.00
Iron Deficiency: -E61.1
Joint Pain: -M25.50
Memory Loss: I69.011
Menopausal Syndrome – N95.1
Menorrhagia – N92.0
Metrorrhagia – N92.4
Mood Swings: -F34.8
Night Sweats: R61
PCOS – E8.2
Peri-Menopause – N95.1
PMDD -N94.3
Routine – Z00.00
Weight Gain – R63.5

Welcome to Better Hormonal Health with Reneu.

Dr. Wohlfeil and her staff are committed to working with you to give you the best hormonal balance, metabolism, immune system and overall well-being. As you know, this is a process that takes time and your commitment. Dr. Wohlfeil is one of the few physicians in the area addressing hormonal concerns with a thorough evaluation and explanation of your particular profile. She is one of the VERY FEW accepting insurance for most visits. This does not guarantee that your visit will be covered by your insurance, or covered in its entirety. We urge you to check with your insurance to see if Dr. Wohlfeil is in your network, what portion of your visit will be covered and what your co-pay will be. We are a small staff at Reneu, and our focus is on patient care. We do not have the resources to "check for you". This is your responsibility. You may also be responsible for the lab work portion of your management. Many insurance companies do not cover testing that is not considered "routine or wellness". For patients in this situation, we have negotiated greatly discounted lab testing thru Quest, Dr. Wohlfeil's preferred lab. Please do not assume your blood work is covered. Again, it will be your responsibility to check with your insurance company. If it is not covered, or partially covered, your best option will be paying out of pocket for your blood work. Insurance price will typically be 3-5 times the discount price. Salivary, urine or blood spot testing my also be recommended by Dr. Wohlfeil. These tests are sent to a ZRT laboratory directly by mail once you have completed them. These tests are not covered by insurance. We strive to keep your care as affordable as possible, but as with most things "you get what you pay for". Your particular set of issues may require more in-depth testing that is not a part of a routine venous blood draw.

Hormonal, metabolic, neurotransmitter, co-factors – all of these substances keep you healthy and balanced. All of these substances are changing as you age, experience stress, change your diet and thousands of other circumstances. After your initial evaluation, Dr. Wohlfeil will want to see repeat lab work and have a follow up to discuss your improvements. Ongoing management for her patients will be, at the minimum, every 6 months. We are committed to making you hormonally and metabolically your best, and this requires a long-term commitment from you as our patient.

I, _____, understand the explanation of hormonal management at Reneu.

Date_____-

Questions or concerns

_____

_____

_____

_____

HIPAA Authorization Form

Reneu Health & Medispa has taken measures to protect all of our patients' private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) **does allow** us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I,_____, **am authorizing** the person/people listed below to obtain medical information about myself. I understand that Reneu Health & Medispa is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name:_____ Relationship: _____
Date of Birth:_____Phone#_____

Name:_____ Relationship: _____
Date of Birth:_____Phone#_____

Name:_____Relationship: _____
Date of Birth:_____Phone#_____

What phone number is best to contact you at? _____
Relationship: _____Is it ok, to leave a detailed message? Yes or No

Patient's Signature:_____Date:_____

In Case of Emergency, I_____am giving Reneu Health & Medispa consent to contact the following person_____at phone #_____.

I,_____, **do not** authorize Reneu Health & Medispa to release **any** of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature:_____Date:_____