New Patient Appointments

Welcome to Forward Health Solutions! We look forward to meeting you. As new patients have many questions, we ask that you please read and sign this document so that we know you received this important information. Thank you!

What to expect at your first visit

During your initial appointment with Dr. Boyd, she will listen to your concerns, review your health history, and discuss your lab results. Then, she will create a plan specific to your needs and goals, and encourage you as you start making changes to improve your health.

Scheduling your appointment

- **Complete the Female or Male New Patient forms and return to us.**
- Once we have received your completed forms, we will call you to schedule your appointment (If you do not hear from us within two business days, please call to make sure we received your paperwork.)

Lab tests prior to your appointment

- **You will need to have your blood drawn for a specific test panel and the completed results received before your appointment.**
- If you have had blood work done within the last two months, please include the results when you send in your new patient forms as you may not have to have those tests redrawn.
- You may have your blood drawn at Forward Health Solutions at a significant savings. Your cost for the panel is $478 for women and $498 for men (as it includes PSA).
- If you wish to have your labs drawn outside, we recommend contacting your insurance company to make sure they will cover the tests. (A list of the lab tests we draw is included in this packet.) Patients having labs drawn elsewhere will need to follow our Outside Lab Policy.

Payment

- **Payment is due at the time of appointment, service or purchase. We accept cash, check, VISA, MasterCard and Care Credit.**
- If you have a question about the cost of an appointment, service or purchase, ask prior to receiving them.
- New patient appointments are generally 60 minutes and are $350
- Follow-up appointments are generally 30 minutes and are $150.
- Patients requiring additional time at either a new patient or follow-up appointment will be charged $150.00 for extra time beyond their appointment time period, not to exceed an additional 30 minutes.

Insurance

Insurance: We do not accept insurance or submit insurance claims for you. Our staff will provide you with a receipt, which includes our NPI number, CPT codes of procedures and diagnosis codes so that you may submit a claim to your insurance company. *Note: We recommend you contact your insurance company to discuss your coverage for an "out of network" provider before being seen. Not all insurance companies will reimburse you for our appointments and services.*

Medicare: Forward Health Solutions is an "opt out" provider, so you may not submit any claims to Medicare for reimbursement.

Appointment Reminders

As a courtesy, we have an *automated* service to remind patients of their appointments. While we make every attempt to reach you, it is still your responsibility to cancel your appointment per our office policy.
Our automated calling system will call you:

- 2 business days prior to your Lab appointment at Forward Health Solutions
- 2 business days prior to your appointment with Dr. Boyd
- 10 business days prior to your appointment with Dr. Boyd to remind you to have your blood drawn at the outside lab you have chosen.

Text messages: If you would prefer to receive a text message reminder, please text FHS TO 622622

I understand that above information and agree to make payment in full at the time of appointment, service or purchase.

Name: _____ Date: _____

NEW PATIENT INFORMATION

PERSONAL INFORMATION			
Name (Last, First, Middle)	Nickname	Date of Birth	Age
Maiden Name	Sex: ☐ Female ☐ Male	Spouse/Parent/Guardian (If under age 18)	
Address			
City, State, Zip Code	Patient Email		
Home Phone	Work Phone	Cell Phone	

EMERGENCY CONTACT		
Emergency Contact Person	Phone	Relationship

EMPLOYMENT INFORMATION	
Employer	Occupation
Business Address	City, State, Zip Code

GENERAL INFORMATION	
How did you hear about our practice?	Who referred you to our practice?

PAYMENT INFORMATION

Agreement to Pay: I understand and agree that I am responsible for payment at the time of my appointment including phone consults, services or when purchasing supplements.

We accept cash, debits cards, checks, VISA, MasterCard and Care Credit. Should your check be returned for non-sufficient funds, you will be charged a $25 NSF fee and you will need to pay with cash or a credit card. Patients are responsible for all costs associated with collections on their accounts.

Medicare Patients: **We are an opt-out provider and you cannot submit a claim to Medicare** to reimburse you for your visits, services or supplements.

Patients Signature	Date

NEW PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

MEDICAL HISTORY

DISEASES/DIAGNOSES/CONDITIONS Check appropriate box and provide date of onset

Past	Ongoing	GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome_____
☐	☐	Inflammatory Bowel Disease _____
☐	☐	Crohn's _____
☐	☐	Ulcerative Colitis_____
☐	☐	Gastritis or Peptic Ulcer Disease _____
☐	☐	GERD (reflux) _____
☐	☐	Celiac Disease _____
☐	☐	Other _____

Past	Ongoing	CARDIOVASCULAR
☐	☐	Heart Attack _____
☐	☐	Other Heart Disease _____
☐	☐	Stroke _____
☐	☐	Elevated Cholesterol _____
☐	☐	Arrhythmia (irregular heart rate) _____
☐	☐	Hypertension (high blood pressure) _____
☐	☐	Rheumatic Fever _____
☐	☐	Mitral Valve Prolapse _____
☐	☐	Other _____

Past	Ongoing	METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes _____
☐	☐	Type 2 Diabetes _____
☐	☐	Hypoglycemic _____
☐	☐	Insulin Resistance or Pre-Diabetes _____
☐	☐	Hypothyroidism (low thyroid) _____
☐	☐	Hyperthyroidism (overactive thyroid) _____
☐	☐	Endocrine Problems _____
☐	☐	Polycystic Ovarian Syndrome (PCOS) _____
☐	☐	Infertility _____
☐	☐	Weight Gain _____
☐	☐	Weight Loss _____
☐	☐	Frequent Weight Fluctuations _____
☐	☐	Bulimia _____
☐	☐	Anorexia _____
☐	☐	Binge Eating Disorder _____
☐	☐	Night Eating Syndrome_____
☐	☐	Eating Disorder (non-specific) _____
☐	☐	Other _____

Past	Ongoing	GENITAL AND URINARY SYSTMS
☐	☐	Kidney Stones _____
☐	☐	Gout _____
☐	☐	Interstitial Cystitis _____
☐	☐	Frequent Urinary Tract Infections _____
☐	☐	Frequent Yeast Infections _____
☐	☐	Erectile Dysfunction _____
☐	☐	Sexual Dysfunction _____
☐	☐	Other _____

Past	Ongoing	MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis _____
☐	☐	Fibromyalgia _____
☐	☐	Chronic Pain _____
☐	☐	Other _____

Past	Ongoing	INFLAMMATORY/ AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome _____
☐	☐	Autoimmune Disease _____
☐	☐	Rheumatoid Arthritis _____
☐	☐	Lupus SLE _____
☐	☐	Immune Deficiency Disease _____
☐	☐	Herpes-Genital _____
☐	☐	Severe Infectious Disease _____
☐	☐	Poor Immune Function _____
		(frequent infections)
☐	☐	Food Allergies _____
☐	☐	Environmental Allergies _____
☐	☐	Multiple Chemical Sensitivities _____
☐	☐	Latex Allergy _____
☐	☐	Other _____

Past	Ongoing	RESPIRATORY DISEASE
☐	☐	Asthma _____
☐	☐	Chronic Sinusitis _____
☐	☐	Bronchitis _____
☐	☐	Emphysema _____
☐	☐	Pneumonia _____
☐	☐	Tuberculosis _____
☐	☐	Sleep Apnea _____
☐	☐	Other _____

MEDICAL HISTORY *continued*

Past	Ongoing	CANCER
☐	☐	Lung Cancer _____
☐	☐	Breast Cancer _____
☐	☐	Colon Cancer _____
☐	☐	Ovarian Cancer _____
☐	☐	Prostate Cancer _____
☐	☐	Skin Cancer _____
☐	☐	Other _____

Past	Ongoing	SKIN DISEASES
☐	☐	Eczema _____
☐	☐	Psoriasis _____
☐	☐	Acne _____
☐	☐	Melanoma _____
☐	☐	Skin Cancer _____

Past	Ongoing	NEUROLOGIC/MOOD
☐	☐	Depression _____
☐	☐	Anxiety _____
☐	☐	Bipolar Disorder _____
☐	☐	Schizophrenia _____
☐	☐	Headaches _____
☐	☐	Migraines _____
☐	☐	ADD/ADHD _____

Past	Ongoing	NEUROLOGIC/MOOD
☐	☐	Autism _____
☐	☐	Memory Problems _____
☐	☐	Parkinson's Disease _____
☐	☐	Multiple Sclerosis _____
☐	☐	ALS _____
☐	☐	Seizures _____
☐	☐	Other Neurological Problems _____

PREVENTATIVE TEST AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ Cardiac Calcification Score _____
- ☐ EKG _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____

SURGERIES

Check box if yes and provide date

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder_____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement- Knee/Hip _____
- ☐ Heart Surgery - Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ Other _____

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us?

_____

If you had a magic wand and could erase three problems what would they be?

1._____

2._____

3._____

When was the last time you felt well?

_____

COMPLAINTS/CONCERNS *continued*

Did something trigger your change in health?

_____

What makes you feel worse?

_____

What makes you feel better?

_____

What have you done that has helped?

_____

ALLERGIES

Medications/Supplement/Food Reaction

_____

_____

_____

MEDICATIONS/SUPPLEMENTS

CURRENT MEDICATION / NUTRITIONAL SUPPLEMENTS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

☐ Yes ☐ No Have your medications or supplements ever caused you unusual side effects or problems?
Describe:_____

☐ Yes ☐ No Have you had prolonged or regular use of NSAIDS (i.e., Ibuprofen / Naproxen)?
☐ Yes ☐ No Have you had prolonged or regular use of Tylenol?
☐ Yes ☐ No Have you had prolonged or regular use of Acid Blocking Drugs (i.e., Nexium)?
☐ Yes ☐ No Antibiotics > 3 times/year
☐ Yes ☐ No History of long-term antibiotics
☐ Yes ☐ No Past use of steroids (Prednisone, nasal allergy inhalers)
☐ Yes ☐ No History of oral contraceptives

CURRENT HEALTH

SLEEP

- ☐ Sleep Well
- ☐ Hard to go to sleep
- ☐ Wake up often
- ☐ Not rested upon waking
- ☐ Snore

How many hours do you sleep

_____

DIGESTION

- ☐ Abdominal pain
- ☐ Burp often
- ☐ Pass gas
- ☐ Heartburn
- ☐ Bloating

BOWLES

Bowel movements, per day:

_____
or

Overall bowel movements per week:

_____

STRESS

Rate your stress level
1-10 (10 being highest)

_____

Main cause of stress

_____
_____

What are you doing to decrease stress

_____
_____

WOMEN

☐ LMP_____

☐ Number of days of last period

_____

☐ Present contraceptive

_____

☐ Menopausal symptoms

☐ When did symptoms start

_____

☐ Leaking urine (incontinence)

- ☐ With coughing, jumping
- ☐ Can't hold urine
- ☐ Go Frequently

MEN

☐ Last Prostate exam(men over 50)

_____

☐ Date of last PSA _____

PSA Level _____

☐ Problems with Erections

☐ Less Strong

☐ Performance decreased

EXERCISE

Current Exercise Program Activity (list type, number of sessions/week, and duration of activity)

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age at death (if deceased)												
Cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast or Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (i.e., Rheumatoid, Psoriatic)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Immune Diseases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies, Sensitivities or Intolerances	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALS or other Motor Neuron Diseases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression / Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Menopause Rating Scale (MRS)

Name: _____Date of Birth_____

Today's Date: _____

Place one "X" for each symptom

Which of the following symptoms apply to you at this time?	**Does not Apply**	**Mild**	**Moderate**	**Severe**	**Extremely Severe**
1. Hot flashes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

OFFICE POLICY

Patient Name: _____ DOB_____

PLEASE INITIAL EACH ITEM BELOW

___ **Primary Care and Emergencies**

- We do not assume treatment of chronic medical illnesses or general medical care (including pap smears, mammograms, and digital rectal exams).
- We do not prescribe refills of your routine medication prescribed by other physicians.

___ **Lab Work**

- **We offer lab work at a significantly-reduced cost compared to many outside clinics.** If you choose to have us do your lab work, allow 3-5 business days prior to your appointment. Payment is due at the time your blood is drawn.
- If you choose to have your labs done at an outside lab, you will also need to sign our **Outside Lab Policy**.

___ **Payment**

- **Agreement to Pay**: I understand and agree that I am responsible for payment at the time of my appointment (including phone consults), services or when purchasing supplements.
- We accept cash, personal checks, debit cards, VISA, MasterCard and Care Credit. Should your check be returned for non-sufficient funds, you will be charged a $25 charge NSF fee and you will need to pay with cash or a credit card. Patients are responsible for all costs associated with collections on their accounts.
- **Insurance Patients**: We DO NOT accept any insurance, nor do we submit claims for you. We would be happy to provide you with an itemized invoice so you may submit it to your insurance company. Note: Not all insurance companies will reimburse you for our services.
- **Medicare Patients:** ***We are an opt-out provider and you cannot submit a claim to Medicare*** for reimbursement for your visits, services, or supplements.

___ **Appointment No-Shows, Cancellation and Late Fees**

- Appointments: Your appointment time is scheduled just for you. We do not double or overbook other patients into your appointment time. ***I agree that if I do not cancel my appointment 24 business day hours prior to my appointment time, (e.g. on Friday morning prior to your Monday morning appointment time) I will be charged $100 for the missed appointment.***
- Late Arrivals: If you will be unavoidably late for your appointment, please let us know. If you arrive more than 15 minutes late, you may be required to reschedule.

___ **Prescriptions Refills**

- Prescription refills should be requested at appointments, whenever possible.
- ***Refill requests should be made at least 2 business days prior to taking your last dose.***
- ***You will be required to have an "in-clinic" appointment annually for any new or refill prescriptions***
- ***If you are taking testosterone or thyroid medications prescribed by Dr. Boyd, you will need to be seen within the last 6 months.***

___ **Confidentiality**

- Your medical information is strictly confidential. We will not release it to anyone, including family members, without your written consent. However, if you wish, a family member may accompany you to your appointments without a written consent.
- If you want a copy of your records sent to another physician, we require a written authorization from you.

___ **Employee Work Environment**

- Forward Health Solutions is committed to providing a work environment for our employees that is free of harassment of any nature, including sexual harassment or harassment based on such factors as race, color, religion, national origin, age, sex, marital status, and disability. Any patient who harasses a staff member or any other patients will be dismissed as a patient.

By signing this form, I acknowledge that I have read and agree to abide by the above office policy. I also understand that if I abuse or do not follow these policies, I may be discharged from the clinic.

Patient Name (Print): _____ Patient Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICE

FORWARD HEALTH SOLUTIONS, PLLC

General: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), set rules that regulate how a person's personal health information can be disclosed to others.

Protected Health Information: This includes oral or recorded information created or received by the healthcare provider, health plan, employers, or others concerning physical or mental health provisions or payment for healthcare.

How your medical information will be used and disclosed: We will use your protected health information as part of patient care. For example, your protected health information may be used by the healthcare professional treating you, by the business office processing your payment for services rendered, or by our staff reviewing the quality and appropriateness of the care received.

We may also use and/or disclose your medical information:

- when required to determine our compliance with relevant laws;
- for public health concerns, such as reportable infections, diseases and injuries.
- in the course of certain judicial or administrative proceedings;
- for law enforcement purposes and /or other specialized governmental functions;
- to a coroner, medical examiner, or funeral director;
- to prevent or lessen a *serious* threat to the health and safety of yourself and others;
- as authorized by laws related to Workers Compensation programs;
- to another provider to whom we refer you to for further care;

- to family members or any other person you specify here:

_____ (please print) and initial _____

Your rights regarding your protected, personally identifiable information include:

- the right to request restrictions on certain uses and disclosures;
- the right to receive communication from us in a confidential manner;
- the right to inspect and obtain your medical information;
- the right to request an amendment to your medical information;
- the right to receive an accounting of the disclosures for up to six years prior to your request;
- the right to request a copy of this notice;
- the right to complain to Forward Health Solutions, PLLC and the U.S. Department of Health Human Services.

Disclaimer: Forward Health Solutions, PLLC strives to respect and maintain our patients' privacy. A new law with legal terms and unmanageable expectations will not suddenly make any healthcare facility perfect. We will continue to make every effort to provide the best quality healthcare to you and your family in a manner that protects your privacy. Further, we will never intentionally breach your confidence by disclosing **private** information without your consent. However, if you feel you have **serious** privacy issues or concerns, you may want to consider using another facility. It is impossible to soundproof our office or guarantee that someone will not overhear a conversation, see your name somewhere, or even meet you in our lobby.

Please speak with any staff member if you have any questions regarding this policy. If you feel your privacy rights have been violated, please contact our Privacy Officer: Joanne Barthel, Forward Health Solutions, PLLC, 140 Mayfair Road, Suite 1700, Hattiesburg, MS 39402, (601) 450-2077

_____	_____	_____
Patient name (Printed)	Patient signature	Date

☐ This does not apply to me. _____ _____
Patient Signature Date

Medicare Private Contract

This agreement is between Rebecca Boyd, D.O., whose principal place of business is 140 Mayfair Road, Suite 1700, Hattiesburg, Mississippi 39402

and

Beneficiary: _____ DOB: _____

Who resides at: _____

And is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective October 1, 2010. The physician is not excluded from participating in Medicare Part B under (1128) 1128, (1156) 1156, or (1892) 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following by placing initials before each statement:

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charges for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees NOT to submit a claim Medicare for reimbursment or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from the physician and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and other supplements plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been available to him.

Signed on: _____Date By:_____ Beneficiary or his/her legal representative

How do I decide where to have my labs drawn?

We are asked that question all the time. In an effort to help you, following are some things to consider:

Forward Health Solutions	Outside Labs
Full Panel Charge - $478 for women, $498 for men (as it includes PSA)	Full Panel Charge – varies greatly. We have had patients tell us they have been charged anywhere between $1500 and $5000.
We generally receive the results in 2-3 business days.	We receive results from most labs in 7-10 business days.
We do not accept insurance. Payment is due in full at the time your blood is drawn.	Many insurance companies require a co-pay, then later will send you a balance for what they do not cover.
We print your invoice for you, so you may submit a claim to your insurance company.	If you have insurance, we recommend that you contact the lab and your insurance company to find out if they will cover the required blood work.
We run a Full Panel to get a more accurate picture of your health.	We use only appropriate diagnoses codes that apply to you and some insurance companies consider the tests we do unnecessary.

OUTSIDE LAB POLICY

Due to the difficulty we frequently have getting test results from outside labs, and patients who do not get their labs drawn early enough to allow for results in time for their appointment, we have implemented this Outside Lab Policy.

New Patient Labs

12 BUSINESS DAYS PRIOR TO YOUR APPOINTMENT:

- Have your labs drawn and call us with the name of the drawing lab.

5 BUSINESS DAYS PRIOR TO YOUR APPOINTMENT:

- If we have received partial results, we will call the outside lab for any missing lab results.
- If we have not received "ANY" lab results, we will attempt to reach you by phone. Provided you have an email on file, we will send you an email notification to cancel your appointment and ask that you call us to reschedule.

2 BUSINESS DAYS PRIOR TO YOUR APPOINTMENT:

- If we have not received "ALL" completed results by noon 2 business days prior to your appointment, we will call you. If we are unable to reach you by phone, we will send an email notification cancelling your appointment and ask that you call us to reschedule.

Established Patient Labs

In order for you to obtain new/refill prescriptions and pellets, you will need to ensure that you complete your labs and have your follow-up appointments. If you fail to do so, you will be unable to get further prescriptions or pellets until you have been seen by Dr. Boyd.

You will be required to have an "in-clinic" appointment annually for any new or refill prescriptions.
If you are taking testosterone or thyroid medications prescribed by Dr. Boyd, you will need to be seen within the last 6 months.

10 BUSINESS DAYS PRIOR TO YOUR APPOINTMENT:

- Have your labs drawn and call us with the name of the drawing lab.

5 BUSINESS DAYS PRIOR TO YOUR APPOINTMENT:

- If we have received partial results, we will call the outside lab for any missing lab results.
- If we have not received "ANY" lab results, we will attempt to reach you by phone.

2 BUSINESS DAYS PRIOR TO YOUR APPOINTMENT:

- If we do not receive "ALL" completed results by noon 2 business days prior to your appointment, we will call you. If we are unable to reach you by phone, we will send an email notification cancelling your appointment and ask that you call us to reschedule.
- If your labs are incomplete, you may still keep your scheduled provider appointment. However, if you keep your appointment, you will be charged for a second appointment to review any missing labs.

LAB ORDERS

- If you request to have your labs done outside, we will:
  - Physically give you a lab order before you leave the clinic, or
  - Email or fax the order to you

- It is your responsibility to provide your lab order to the outside lab you have chosen. ***We will no longer mail, fax, or email any lab orders to outside labs.***

- If you misplace your lab order, please ***contact us one full business day before your lab appointment*** to allow us time to send to your email address.

By signing this form, I acknowledge that I have read and agree to abide by the above Outside Lab Policy.

_____	_____	_____
Patient name (Printed)	Patient signature	Date

Forward Health Solutions, PLLC
140 Mayfair Road, Suite 1700
Hattiesburg, MS 39402
Phone: 601-450-2077
Fax: 601-450-2079

NEW PATIENT LABS

Following is a list of labs that we request all patients have completed for new patient appointments. The first group is for both female and male. Males will have the PSA done in addition to the other tests.

25-OH Vitamin D
CBC **w/ Auto Diff** – Complete Blood Count
CK, Total – Creatine Kinase
CMP – Comprehensive Metabolic Panel
CRP, hs – C-Reactive Protein
DHEA-S
Estradiol
Ferritin
Fibrinogen
Hemoglobin A1C
Homocysteine
IGF-1
Insulin, Fasting
Lipid Profile
LP (a) – Lipoprotein
Progesterone
SHBG – Sex Hormone Binding Globulin
Testosterone, Free & Total
TSH
Free T3
Free T4

PSA