Stefanie A. Schultis, M.D
110 Lakeview Drive Ste 100 Covington, LA 70433
985-898-1940 www.stefanieaschultismd.com

Revised 6-25-20

Patient Demographics

PATIENT INFORMATION	INSURANCE INFORMATION/CASH PATIENT
Name	
Date of Birth: Age:	HMO PPO OTHER Cash Patient
Social Security #:	MUST COMPLETE INSURANCE INFORMATION
Address:	Name of Insurance:
City, State, Zip:	Name of Insured:
Home#: Cell#:	Relationship:
Work#: Primary#:	Social Security#:
Email:	Date of Birth#:
Religion: Ethnicity:	Employer:
Employer:	Policy#: Group#:
Occupation:	Secondary Insurance:
Marital Status:	
Spouse/Guardian:	Name of Insured:
Date of Birth: Social Security#:	Relationship:
Employer:	Date of Birth: Social Security#:
Occupation: Phone#:	Policy#:
Primary Care Physician:	Group#
Referred by:	
Preferred Pharmacy: Phone#	

Notify in Case of Emergency other than Spouse/Guardian
Name: Relationship: Phone#:

I hereby authorize Dr. Stefanie Schultis and/or her staff to communicate my test results.

Can we call you at: **Home:** YES NO **Cell:** YES NO **Work:** YES NO

Can we leave a message at: **Home:** YES NO **Cell:** YES NO **Work:** YES NO

How did you hear about us?

I hereby authorize Dr. Stefanie Schultis and/or her staff to communicate my test results and/or my medical records to the following:

Name:_____Relationship:_____

Name: Relationship:

Patient or Responsible Party Signature: Date:

STEFANIE A. SCHULTIS, M.D.

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Revised 6-24-20

Social

( ) I am sexually active. ( ) I want to be sexually active.
( ) I am absolutely sure I will not attempt to father any more children.
( ) I have used steroids in the past for athletic purposes.

( ) I smoke cigarettes or cigars. How many per day?_____ ( ) I drink alcoholic beverages. How many per week?_____
( ) I drink more than 10 alcoholic beverages a week. ( ) I use caffeine. How much per day? _____

( ) Any known drug/latex/tape/food allergies?_____

Medical History

Medical Illnesses:

( ) High Blood Pressure
( ) High Cholesterol
( ) Diabetes
( ) Depression/Anxiety
( ) Thyroid Disease
( ) Heart Attack
( ) Heart Disease
( ) Carotid Artery Blockage
( ) Cardiac or Coronary Artery Stents
( ) Stroke
( ) Blood clot and/or pulmonary emboli
( ) Hemochromatosis
( ) Chronic Liver Disease (hepatitis, fatty liver, cirrhosis)
( ) Arthritis

( ) Testicular or Prostate Cancer When?_____
( ) Other Cancer (type)_____
( ) Elevated PSA
( ) Prostate Enlargement
( ) Trouble passing urine or take Flomax or Avodart

Have you ever had issues with anesthesia? ( ) Yes ( ) No If yes, please explain_____

Medications Currently Taking:_____

Current Hormone Replacement Therapy:_____

Past Hormone Replacement Therapy:_____

Nutritional or Vitamin Supplements:_____

Surgeries: List all and when:_____

_____

Other pertinent information:_____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and, if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of my system in 12 months.

Signature_____Print Name_____Date_____

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Revised 6-25-20

Well-Being Checklist for Men

Name_____Date_____

Email_____

Symptoms (please check)	None	Mild	Moderate	Severe
Decline in general well-being				
Join pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining mental ability/focus				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight gain/belly fat				
Breast development				
Shrinking testicles				
Rapid hair loss				
Decrease in beard growth				
New migraine headaches				
Decreased desire/libido				
Infrequent/absent ejaculations				
No result from ED medications				

Other symptoms that concern you:

_____

_____

_____

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Erectile Dysfunction Intensity Scale

	Almost Never or Never	A few times (much less than half the time)	Sometimes (about half the time	Most times (much more than half the time)	Almost always or always
How often are you able to get an erection during sexual activity?	1	2	3	4	5
When you have erections with sexual stimulation, how often are your erections hard enough for penetration?	1	2	3	4	5
When you attempt intercourse, how often are you able to penetrate your partner?	1	2	3	4	5
During sexual intercourse, how often are you able to maintain your erection after you have penetrated your partner?	1	2	3	4	5
	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse?	1	2	3	4	5

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted and required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, or your child, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your/your child's protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital surgery may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information,

You have the right to request restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. if any. of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice,

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before APRIL 14, 2013

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer, Heather Harris in person or by phone at 985-898-1940

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature_____

Print Name_____Date_____

Stefanie A. Schultis, M.D.
110 Lakeview Drive Suite 100
Covington, LA 70433
985-898-1940

General Consent to Treat/Patient Authorization/Acknowledgement of Benefits Release

The following are the conditions for services provided by Stefanie A. Schultis, M.D. for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT
I/we voluntarily consent to medical treatment and diagnostic procedures provided by Stefanie A. Schultis, M.D. and other personnel. I/we consent to the testing deemed advisable by my physician. I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION
Stefanie A. Schultis, M.D. is authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, further medical treatment, insurance and/or any third party payer, test results and findings made during the course of the examination or treatment. I/we agree to release of medical and other information about me given to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS
I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the practice of Stefanie A. Schultis, M.D. I/we understand that I am responsible for any charges not covered by insurance or other forms of benefits. I/we shall pay all collection fees and costs. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I/we have received a copy of the NOTICE OF PRIVACY PRACTICES. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the NOTICE MAY BE CHANGED at any time.

_____Date_____
Patient Signature / Legal Guardian

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Revised 5-14-2020

FINANCIAL AND CANCELLATION POLICIES – Hormone Pellets, PRP and Laser Services

Financial

Thank you for choosing us for your medical needs. Some services are not covered by insurance. Payment may be due on the day of service. A $250 deposit may be required at time of scheduling specific procedures.

Packages are expected to be paid as per package contract. Cash, checks and major credit cards (3.5% service charge will be added to credit card payments) are accepted. We can assist you in applying for healthcare financing, if requested.

Cancellations

Cancellations must be 24 hours before your scheduled service or a $50 charge will be applied to your service.

For **NO SHOW's** The $250 deposit will not be refunded.
Please understand if you do not cancel timely, we cannot schedule another patient who may be in need.

I have read and understand the Financial and Cancellation Policies.

_____Date_____
Signature of Patient or Responsible Party

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Revised 12-18-19

Priapus-Shot™ Pre and Post Care Instructions

The P-Shot™ should not be used in patients who have areas of active inflammation or infection (cysts, pimples, rash), sexually transmitted diseases or blood-borne infections. Ideally a urological exam within the last 1-2 years by a primary care physician or urologist is recommended.

Pre-Care Instructions

- Stop or reduce all anti-inflammatories, i.e., ibuprofen, advil, aleve, aspirin, steroids for 48 hours prior to your procedure if medically acceptable. We **want inflammation** to occur!
- Stop or reduce non-prescription blood thinning agents, i.e., vitamin E, A, Ginkgo, Garlic, Flax for 48 hours prior to your procedure if medically acceptable.
- **DO NOT STOP PRESCRIPTION ANTI-COAGULANTS.**
- Iron, Vitamin D and other supplements are ok to continue.
- Stop or limit smoking for 72 hours prior to your procedure. The longer the better as we find it impacts the healing process.
- Take all other regular medications as prescribed.
- Come with clean genitalia and clipped short pubic hair.
- Increase your fluid intake the day before your procedure just by simply drinking more water.
- On the day of your procedure, eat normally and continue to drink plenty of water.
- Please bring a book, e-reader or any other device to use while the numbing cream takes effect.
- If you haven't already signed the consents and filled out the sexual health survey, you can download from our website, https://www.stefanieaschultismd.com/patient-resources and bring with you the day of the procedure.

Post-Care Instructions

- Discomfort/ redness/swelling/numbness/bruising and tenderness to the touch is normal for a few days to a week or more.
- You may notice reaction from mild to intense sexual sensitivity, want/need for sex, sexual drive/libido, increase in erection, ability to maintain erection and length/girth/firmness in the first 3-5 days which will be due to the swelling.
- Bath or showers are fine. Clean treatment area twice daily with mild soap and water.
- Sexual activity maybe engaged immediately.
- You may have no effect at all in the first few weeks.
- Real benefits may not present for 4-12 weeks or not at all.
- You should use the vacuum penis pump for 10 minutes two times per day and keep the pressure between 5-10. You should stop using the pump if you have excessive swelling or discoloration.
- Please stop or reduce any anti-inflammatories, aspirin or steroids if medically able for 5-7 days.
- Continue to limit above listed non- prescription blood thinners and anti-inflammatories if medically able for 5-7 days. We **want inflammation** to occur!
- Avoid smoking for as long as possible for better results and healing!
- Notify Dr. Schultis' office with any extreme reactions.

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Revised 5-14-20

Consent for Priapus Shot® Treatment

A. Purpose

Using injections of blood-derived growth factors, (PRP) for rejuvenating, enlarging and strengthening the penis. Nothing contained in this consent form or in any other information provided to potential patients is intended to represent a promise, guarantee or warranty that any patient who undergoes the P-Shot™ will achieve a desired result.

B. Benefits

The treatment is natural in that your own cells are used, treated with a substance that is not foreign to the body and injected into the specified areas. Since a distillate of growth factors from your own blood, (PRP) is used, there should be no side effects from the material injected. The body reacts to the treated cells as it does to a wound and immediately started repairing the tissue. This builds the underlying tissue with a possible (but not guaranteed) 10 to 20% increase in length and girth. You may see improvements immediately, that only last 3-5 days as the water is absorbed. Your normal status will then resume. You may see benefits from the cellular regeneration process in about 4 weeks with continued improvement possible up to 12 weeks. Within 4 weeks an increase in girth and length is common. There's actual growth of new tissue by stimulation of uni-potent stem cells, so the change in shape is not from something foreign from being in the body but from the body actually rejuvenating and growing. The PRP stimulates new blood flow with new blood vessels (neovascularization).

The results of this treatment if obtained vary and may last varying lengths of time. Some people report up to 15-18 months. Some people may note the procedure leads to enlargement of the penis, strengthening of the penis, straightening of the penis, increased circulation within the penis for a healthier organ, other therapies work better (if you still need Viagra or Cialis) then it may work better, increases in sensation and pleasure.

C. Treatment

A numbing cream (lidocaine, bupivacaine, and tetracaine) is applied to the treatment areas.
Your blood will then be drawn in the same way blood samples are taken for routine blood tests.
The tubes of blood are centrifuged to separate the component cells. Platelets are separated and used for the procedure.
The platelets are treated with calcium chloride or gluconate which acts as an activator for the plasma cells. The platelets then release growth factors into the liquid in the tube. The liquid is transferred into a syringe and then injected into the penis using a small needle.

D. Foreseeable Risks and Discomforts

The primary risks and discomforts are related to the blood draw where there is a slight pinch to insert the needle for collection and there is a potential for bruising at the site. The injections at the treatment locations may cause pain similar to an intramuscular injection. Therefore, the numbing cream and small needles are used.

Smokers have less positive response to this treatment than non-smokers since the toxins in the tobacco block the response of the stem cells. Anti-inflammatories and steroid usage will also block the response of the stem cells.
There will be variation in results as everyone's body type is different and will have a different response.

I understand risks associated with the proposed procedure(s) to be:

Allergic reactions including to injections and or creams used for pain relief
Pain during treatment (failure of anesthesia to prevent pain)
Post procedure pain- short and/or long term
Swelling, bruising, bleeding, numbness, infection, slow healing, hematoma at injection sites

Damage to nearby organs (i.e. bladder, urethra)
Urinary changes (i.e. frequency, urgency, nocturia, retention, feeling like need to empty bladder all the time)
Change in urinary stream
Urinary tract infections (acute or chronic), hematuria
Scarring of penis
Fatigue
Nerve Damage

Failure to obtain desired benefits
Varied results
Sexual Function alteration (increase or decrease)
Mental preoccupation of the penis
Alteration of the function of the penis and the male sexual response cycle
Alteration of penile sensations (including but not limited to a sensation of always being sexually aroused or loss of sensation)
Psychological or relationship or sex life disturbances

E. Consent for Anesthesia

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

F. Other Risks

I understand that there may be 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.

G. PRP and Other Alternative Treatments

I understand that the use of PRP in this procedure is an "off-label" use and no promise or representation, guarantee or warranty regarding its use, benefit or other quality has been made. No representations that the use of the product and this procedure is approved by the FDA or any other agency of the federal or state government has been made. I understand the alternatives to the proposed procedures and related risks to be:

-do nothing _____

H. Payment

I understand that this procedure is not covered by insurance and that payment is my responsibility.
Payment is required at time of service is non-refundable. I also understand the cost of additional treatments, including enhancements, in order to help me achieve my desired goals, will be my financial responsibility.

<u>The following to be completed with physician.</u>

I have read the above document and understand it. The healthcare provider has answered all of my questions satisfactorily. I accept the risks and complications of this procedure.

Patient Signature:_____ Date:_____

Printed Name:_____

Healthcare Provider Signature:_____ Date:_____

Printed Name:_____