

REVOLUTIONARYMD | REGISTRATION

Today's date: _____

Last Name _____ First Name _____ DOB _____

Address _____ Apt _____

City _____ State _____ Zip _____

Cell phone _____ Email: _____

Please note, email will not be given to others and will be added to our occasional newsletter unless you don't want it.

Weight _____ Height _____ Sex F M Please circle | Married Single Partner Divorced

Employer _____ Occupation _____

EMERGENCY CONTACT

Name _____

Relationship _____ Phone _____

HEALTH INFORMATION QUESTIONNAIRE

Chronic Medical Problems with date of onset

1. _____

2. _____

3. _____

4. _____

5. _____

Surgeries with approx. dates

1. _____

2. _____

3. _____

4. _____

5. _____

Please list **Medication Allergies** and reactions you've had, write "none" if you don't have any.

Non-Med Allergies (ie: food, pollen, pets mold, etc.) _____

Please list **Medications** you are taking with dosage:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Please List any **Supplements** (vitamins or herbs) with dosage: use back if needed

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

FAMILY HISTORY:

Problem	Family Relation	Describe any Details	Age of Death if applies
High Blood pressure			
Heart attack or disease			
Stroke			
High Cholesterol			
Diabetes			
Thyroid disease			
Depression or other			
Alcoholism			
Cancer			
Other			

Lifestyle Q's	
Exercise: How often? Aerobic/Resistance?	
Diet: Balanced? Limiting fast foods?	
Mindful activities? Yoga, meditation etc?	
Tobacco? Type, how much, how long?	
Alcohol: How much?	
Street drugs?	

PREVENTATIVE SCREENING

Women/Men over 50

___yes ___no Have you had a colonoscopy or other form of colon cancer screening?
 Now recommended to start at 45. Results and year last performed?

___yes ___no Any 2nd hand smoke exposure for >20 years

___yes ___no If **over 50**, have you had the shingles vaccine (Shingrex)?

___yes ___no If **over 65** have you had a pneumonia vaccine (pneumovax)?

___yes ___no Last tetanus shot approximate year _____ (update every 10 yrs)

___yes ___no Ready or desire a flu shot?

___yes ___no Interest in Cleerly Heart Scan or Prevencio Cardiovascular screening?

Women

When was your last pap smear? _____ Any abnormal? _____
If yes, what year _____
If over 50, when was your last mammogram? _____
Bone density osteoporosis screen yet if over 50? _____
results _____

Men over 50

When was your last prostate cancer screening? Last PSA? _____

Covid vaccination and history-

Are you up to date on Covid vaccine immunizations? __ yes __ no

Have you had Covid? __ yes __ no If so when? _____

What are the key issues you'd like to address today?

How did you hear about us? _____

Please list any *integrative/functional medicine therapies* you have received or are undergoing

Please list the names of other people who live with you if applicable

Is your life balanced? _____

Are you happy? _____

Do you feel spiritually connected to a religion, nature, etc? _____

Is there anything else concerning you such as domestic violence, or abuse that you'd like to discuss? _____

Any other comments _____

Advanced Wellness Program (AWP)

Dr. Grover requires patients to be enrolled in the AWP if you plan to have him provide ongoing medical or hormone balancing. The program includes up to 10 visits a year and discounts on skin care services, and all products. Please see the new patient packet for details on this program. You can sign up for this at your 2nd visit if you are unsure, and please feel free to ask us if any q's. If you are only doing a procedure such as IV therapy, weight loss, Botox, Juvederm, laser therapy, PRP as a stand-alone you do not need to join this program. You will get discounts on these services being in the AWP however.

Bio-identical Hormone balancing/Sex Hormone Balancing

Dr. Grover is an expert in hormone replacement and is board certified in anti-aging/regenerative medicine.

Do you have an interest in hormone testing and restoration? __ yes __ no

Hormone pellet therapy also available. Any interest? __ yes __ no

Thyroid/Adrenal /Growth hormone balancing

Dr. Grover also specializes in the treatment of hypothyroidism, subclinical hypothyroidism, adrenal fatigue, growth hormone deficiency. Are you interested in screening or treating this condition? ___yes ___no

IV therapies We offer a variety of IV therapies including NAD+ to support mitochondrial function, Vitamin C, glutathione and others. Any interest? __ yes __no

Ketamine is also offered in our unique sound therapy suite to help with the treatment of depression, anxiety, PTSD. Any interest? __ yes __no

Sexual Health

We offer the Alma Duo for improved/regenerative male and female sexual sensitivity and function. This is a non-invasive painless sound wave like therapy, similar to the waves used to break up a kidney stone. Any interest in hearing more? __ yes __no

Aesthetic Dermatology

As part of his anti-aging services, we offer skin care treatments including Botox, Juvederm, (other fillers too) Kybella, laser, IPL, Vivace Microneedling. Dr. G has been injecting since 2005.

Any interest in this anti-aging skincare therapy? ___yes ___no

Kybella Therapy is available for treatment of the double chin, aka turkey gobbler! This is an easy in office treatment with small injections under chin. Any interest? ___yes ___no

Platelet Rich Plasma Therapy (PRP)

Dr. Grover is a certified and experienced PRP injector. Are you interested in PRP for facial or other regions of rejuvenation? ___yes ___no

Peptide therapy

We offer semaglutide for weight loss therapy as well as other regenerative peptides. Any interest __yes__no

PEMF Therapy-

We offer the most powerful and therapeutic pulsed magnetic therapy available in the country via the PulsePro. This can help reduce inflammation and improve bone density. Any interest? ___yes__no

Genetic testing

Dr. Grover offers testing to cancer risk (Galleri), and additional tests to assess detox/methylation (mthf) impairment, optimal diet for your gene type, and other health conditions to optimize your wellness.

Any interest? ___yes ___no

HIPPA

- I authorize the release of medical information if necessary to process my insurance claim. _____(initial)
- I have reviewed Dr. Grover's Notice of Privacy Practices, (waiting room book) which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so request. _____(initial)
- Please circle which phone number we may use to leave detailed information: (home, cell or office)
- I give permission to leave health information on voicemail ___yes ___no
- I give permission send health information by email. (excluding HIV), ___yes ___no

GUARANTOR

Person responsible for the bill | Self____ Spouse____ Parent____ Other____

If different than self, please fill in below-

Last Name_____ First name_____

Address_____ Apt._____

City_____ State_____ Zip_____

Phone | (C)_____ (W)_____

FINANCIAL POLICY

Thank you for choosing Dr. Grover as your health care provider. We are committed to providing the most successful treatment options for our patients. Our charges are reasonable given the higher degree of personalized care, and pro-active management of your health via Integrative, Anti-Aging, Functional, and Family Medicine expertise of Dr. Grover. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. We do not take insurance, but you can submit the superbill on your own to the insurance company. We will provide codes for you to submit in a superbill if desired, but cannot guarantee that any portion of fees will be covered by a particular plan. I cannot engage in phone calls or letters with insurance plans, as it is extremely time consuming, and a major reason I stopped taking them. The codes I give you to submit will be the best that one can provide based on an up-to-date electronic medical record, therefore additional code requests from insurance will be an attempt by them to avoid payment and a task I cannot engage in.

All patients must complete our patient registration form before seeing the practitioner.

- We accept cash, checks, MasterCard and Visa.
- The fee for a returned check is \$50.
- Patients are responsible payment after completing patient visit on day of service.
- Advanced wellness program may incur additional fees for surgical supplies used, or vaccines or other injectable (ie: B12, Botox etc) given.
- Refer to Advanced Wellness Plan Membership Agreement for full details.
- You may mail the superbill invoice if requested with codes for reimbursement to your insurance company. Reimbursement will vary, and we cannot participate in appeals on denied reimbursement. In most cases with PPO plans, you should be able to submit for at least partial reimbursement. HMO's however (ie Kaiser), are restrictive and unlikely to reimburse to an out of network provider. You cannot submit to Medicare/Medicaid, since I have opted out of these
- **Labs** are typically done through Quest, Labcorp, Genova, Boston Heart and a few others. Most labs are covered under insurance plans, but it is always a good idea to check with them or read their policy to see if they are covered.
- **Advanced Wellness Program Reimbursement from plans**
I can give you receipts with codes to apply to Flex, Health Savings accounts and insurance plans for the individual visits. The amount they may reimburse if variable, and may not be covered if they have exclusions for preventative care, and out of network providers. You cannot submit the invoice for the whole year to insurance. They will only recognize individual coded office visits. Pricing for our annual

plan is very reasonable compared to other providers locally and nationwide, and includes numerous additional services that other concierge practices don't provide.

- **Prescription refills** should be called in no less than **4 days prior** to needed refill. Please call your pharmacy and have them fax us the refill request. **303-974-5945**. If unable to have to have a pharmacy fax us, then call our main number to help process. Please do not call my cell phone for refills!
- Patients are responsible for providing prescription **prior authorization forms** and mail in pharmacy forms if needed from their insurance company. Please fill them out prior to faxing or giving them to us. Please check with your plan to see if an generic alternative is available that does not require a prior auth. Calling a **mail-in pharmacy** is very time consuming, so please have them fax me, send e- prescribe request, or bring in the forms for me to fill out for you to mail. They do not function like a normal pharmacy, and impose numerous hurdles to docs/patients to discourage prescribing.
- **Appointments cancelled** less than 24 hours prior to a scheduled time may be subject to a \$50 cancellation fee. 3 or more missed appointments without notification will result in dismissal from practice.
- I have read the policies presented above. I understand and agree to this financial policy. A copy of this is available on our website in the patient registration should you need one for reference.
- Please be sure to fill out our advanced wellness program agreement and sign up today or at your follow-up visit if you plan to receive medical and or hormonal care with Dr. Grover.
- **Thank you for your time in reading and filling out our paperwork and welcome to the practice!!!**

Signature of Patient or Responsible Party

Date