Female Patient Information_2025

First Name
Courtney

Last Name
Hunt

Date of Birth
07/29/1976

Home Address:
19860 N Pepka Ct

City:
Maricopa

State:
Arizona

ZIP Code:
85138

Email:
chunt4326@gmail.com

Cell Phone:
6023123168

Primary Language:
English

Marital Status
Married

Sexual Orientation:
S

If Other, Please Elaborate:
-

As a convenience to our patients, we offer appointment reminders through phone calls and text messages. Would you like to be set up on automatic text reminders?
Yes

If yes, who is your cell phone provider?
Verizon

Next of Kin

Name:
Adam Hunt

Relationship:
Spouse

Phone Number:
6023123168

PREFERRED PHARMACY & LOCATION:
Maricopa walgreens

Primary reason for visit:
Hormone check in due to normal aging

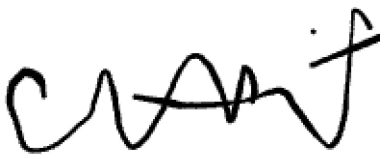
How did you hear about Balance Hormone Center?
Jen Chaturvedi

I hereby authorize the staff of Balance Hormone Center to provide such medical services, either regular or emergency,not limiting to Hormone Replacement or Weight Loss, as may be determined by my physician to be in the patient's (me or my dependent, if signing for minor) best interest. I authorize payment of medical benefits to Balance Hormone Center. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. In the event it becomes necessary for Balance Hormone Center to forward my account balance to an outside collection agency, I understand I will also be responsible for paying a $30 collection fee. I hereby authorize Balance Hormone Center to release the necessary information regarding me to my health insurance plan in order to complete and process my insurance claims.

Signature: (ESign)

Print:
Courtney Hunt

Date:
06/10/2025



Date : June 10, 2025 11:47:12

MEDICAL HISTORY

Please check those which you have or have had

- [x] None/ NA
- [ ] Arthritis
- [ ] Blood Disorder
- [ ] Cancer
- [ ] Diabetes
- [ ] ENT Problems
- [ ] Gastrointestinal
- [ ] Urinary/Prostate
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Kidney Problems
- [ ] Liver Problems
- [ ] Lung Problems
- [ ] Musculoskeletal
- [ ] Stroke
- [ ] Seizure
- [ ] Psychiatric
- [ ] Skin Disease
- [ ] Thyroid
- [ ] Sleep Apnea

Reason for visit/Ongoing Medical Problems

- [x] Difficulty Sleeping
- [x] Muscle and/or Joint Pain
- [ ] Night Sweats
- [ ] Vaginal Dryness
- [ ] Mood Swings
- [ ] Fatigue
- [ ] Hot Flashes
- [ ] Decrease Sex Drive
- [ ] Foggy Thinking
- [ ] Painful Intercourse
- [ ] Difficulty Concentrating
- [ ] Anxiety
- [ ] None/ NA

Sleep

Sleep Quality
Moderately Interrupted Sleep

How often do you dream
1-2x per week

Surgeries/Major Events

- [x] Wisdom Teeth
- [ ] Hysterectomy
- [ ] Joint Surgery
- [ ] C-Section
- [ ] Gallbladder
- [ ] Breast Biopsy
- [ ] Breast Augmentation
- [ ] Tonsillectomy
- [ ] Uterine Biopsy
- [ ] Hernia Repair
- [ ] Appendectomy
- [ ] None/ NA

MENSTRUAL HISTORY

- [x] Currently have regular menstrual cycles
- [ ] Ablation
- [ ] Hysterectomy
- [ ] Menopause
- [ ] None/ NA

PREGNANCY HISTORY/PREVENTATIVE CARE

Are you currently, or do you think you might be pregnant?
No

Date of last menstrual period?
06/09/2025

# of Pregnancies
3

Miscarriages
0

Live Births
0

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS?
Circle a choice that fits best

1. Little interest or pleasure in doing activities.
Not at all

2. Feeling down, depressed or hopeless.
Not at all

PREVENTATIVE CARE

Last Mammogram _____ Abnormal?
No

Any history of abnormal mammogram(s)?
No

Last Pap Smear _____ Abnormal?
No

Any history of abnormal Pap Smear?
No

FAMILY HISTORY

Father Age
80

Medical Conditions
Arthritis

Mother Age
79

Medical Conditions
Stroke, diabetes, aortic congenital defect, benign breast lumps

Brother or Sister Age
51

Medical Conditions
Alcoholic

Brother or Sister Age
47

Medical Conditions
None

Brother or Sister Age
-

Medical Conditions
-

Brother or Sister Age
-

Medical Conditions
-

Maternal Grandfather Age
Deceased @ 74

Medical Conditions
Emphysema, diabetes

Maternal Grandmother Age
Death @ 78

Medical Conditions
Breast cancer (2 xs), blood cloths, diabetes

Paternal Grandfather Age
Died young due to tuberculosis durring ww2

Medical Conditions
Tuberculosis

Paternal Grandmother Age
76

Medical Conditions
Congenital heart disease

SOCIAL HISTORY

Tobacco
- [x] No
- [ ] Yes

Packs/Day
-

Alcohol
- [x] Yes
- [ ] No

Drinks/Week
1 drink / month

Caffeine
- [x] Yes
- [ ] No

Cups/Day
2-3 /day

Exercise
- [x] Yes
- [ ] No

Days/Week
5+ days per week

- [ ] # of Children *

Please mention # of Children
3

- [ ] Desire More Children *
- [ ] Recreational Drugs *

OCCUPATION:
School psychologist

Allergies
Asthma & seasonal pollen.
Nightshades

Current Medications
- [x] none
- [ ] ADD
- [ ] Antidepressant
- [ ] Antacid
- [ ] Blood Pressure
- [ ] Diabetic
- [ ] NSAID
- [ ] Statin
- [ ] Steroid
- [ ] Thyroid

Please list all current supplements you are taking and the dosage
- [x] Fiber
- [x] MultiVitamin
- [ ] Calcium
- [ ] Fish Oil
- [ ] Hair/Skin/Nail
- [ ] Hormone
- [ ] Iron
- [ ] Joint
- [ ] Sleep
- [ ] Sport
- [ ] Vitamin D
- [ ] Weight Loss
- [ ] None

I hereby certify that the previous questions were answered accurately.
I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: (ESign)

Date:
06/10/2025

Date : June 10, 2025 11:56:41

Symptoms Form

GENERAL:

- [x] Abnormal Weight Gain
- [ ] Abnormal Weight Loss
- [ ] Night Sweats
- [ ] Appetite Change
- [ ] Decreased Appetite
- [ ] Fatigue

EYES:

- [x] Blurry Vision
- [ ] Double Vision
- [ ] Visual Disturbances
- [ ] Other
- [ ] None

If Other, Please Elaborate:

-

CARDIOVASCULAR:

- [x] None
- [ ] Chest Pain/Pressure
- [ ] Fainting
- [ ] Palpitations
- [ ] Dizziness
- [ ] Other

If Other, Please Elaborate:

-

RESPIRATORY:

- [x] Wheezing
- [ ] Shortness of Breath
- [ ] Coughing
- [ ] Other
- [ ] None

If Other, Please Elaborate:

Asthma

GI:

- [x] None
- [ ] Persistent Nausea
- [ ] Abdominal Pain
- [ ] Heartburn
- [ ] Vomiting
- [ ] Difficulty Swallowing
- [ ] Other

If Other, Please Elaborate:

-

GENITOURINARY:

- [x] None/ NA
- [ ] Urinary Frequency
- [ ] Night Time Urination
- [ ] Pain with Urination
- [ ] Urinary Urgency
- [ ] Urinary Hesitancy
- [ ] Blood in Urine
- [ ] Other

If Other, Please Elaborate:

-

NEUROLOGIC:

- [x] None/ NA
- [ ] Headaches
- [ ] Numbness
- [ ] Weakness
- [ ] Tingling
- [ ] Poor Balance
- [ ] Decreased Mental Focus
- [ ] Foggy Thinking
- [ ] Other

If Other, Please Elaborate:

-

ENT:

- [x] Nasal Congestion
- [ ] Hearing Loss
- [ ] Dizziness
- [ ] Ear Pain
- [ ] Other
- [ ] None/ NA

If Other, Please Elaborate:

-

MUSCULOSKELETAL:

- [x] Other
- [ ] Joint Pain
- [ ] Decrease in Strength
- [ ] Decrease in Endurance
- [ ] Decrease in Muscle Size
- [ ] Decrease in Performance
- [ ] Swelling
- [ ] Muscle Pain

If Other, Please Elaborate:

Frequent hip muscle pulling/tears & hip pain

SKIN:

- [x] Other
- [ ] Rashes
- [ ] Acne
- [ ] Suspicious Skin Lesions

If Other, Please Elaborate:
Dry

PSYCHIATRIC:

- [ ] Anxiety
- [ ] Depression
- [ ] Insomnia
- [ ] Irritability
- [ ] Other

If Other, Please Elaborate:
-

ENDOCRINE:

- [x] Excessive Thirst
- [x] Hot/Cold Intolerance
- [ ] Other

If Other, Please Elaborate:
-

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are required to honor this agreement (except under an emergency situation). The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- ❖ Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- ❖ This practice reserves the right to change the privacy policy as allowed by law.
- ❖ This practice has the right to restrict the use of the information.
- ❖ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- ❖ This practice may condition receipt of treatment upon the signing of this consent.

May we phone, email or send a text to you to confirm appointments?	May we leave a message on your answering machine?
Yes	**Yes**

I authorize that the following individual(s) may have ongoing access to my protected Health Information:

Printed Name:	Phone Number:	Relationship:
Courtney Hunt	**6023123168**	**Self**
Printed Name:	Phone Number:	Relationship:
-	-	-
Printed Name:	Phone Number:	Relationship:
-	-	-

This consent was signed by:(Printed Name)	SIGNATURE: (ESign)	DATE:
Courtney Hunt		**06/10/2025**

Date : June 10, 2025 12:01:15

NOTICE OF PRIVACY PRACTICES Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Balance Hormone Center, PLLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change, and we have reserved the right to change it. If we change our notice, you may obtain a copy of the revised notice by contacting our office. If you have any questions about our Novice of Privacy Practices, please contact: Balance Hormone Center 3530 S Val Vista Drive, Suite 214 Gilbert, AZ 85297 480.718.9960

I acknowledge receipt of the Notice of Privacy Practices of Balance Hormone Center, PLLC

Signature/Patient (ESign)

Date : June 10, 2025 11:56:41

Date:
06/10/2025

OR I acknowledge receipt of the Notice of Privacy Practices of Balance Hormone Center, PLLC on behalf of
Courtney Hunt

Signature or Guardian (ESign)

Date : June 10, 2025 11:56:41

Date:
06/10/2025

FINANCIAL RESPONSIBILITY AGREEMENT

I understand the self-pay initial consult fee for my hormone replacement therapy visit with Balance Hormone Center is $135. This charge does not include any treatment cost, pellets, injections, supplements, pharmacy medications, or lab testing. I understand the self-pay follow-up visit fee for my hormone replacement therapy visit with Balance Hormone Center is $75. This charge does not include any treatment cost, pellets, injections, supplements, pharmacy medications, or lab testing. If paying out of pocket for lab testing the fee must be paid at the initial new patient visit .

I understand that if I have provided Balance Hormone Center with my insurance information that I will be charged according to the contracted rates between Balance Hormone Center and my insurance company. I understand and agree that I will be financially responsible for any and all charges for services rendered and not paid by my insurance. This includes any medical services or visits, hormone replacement therapy, weight loss treatment, preventative exam/physical, lab or diagnostic testing, and any other services performed by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), hormone replacement therapy, weight loss treatment, preventative exam/physical, lab, or diagnostic testing, or any other service performed by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-pay, co-insurance, out-of-network, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out-of-pocket expenses to me. I understand this and agree to be financially responsible and make full payment.

I hereby authorize payment of benefits to go directly to **BALANCE HORMONE CENTER** for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employee’s agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

Printed Name:
Courtney Hunt

Signature: (ESign)

DATE:
06/10/2025

Date : June 10, 2025 11:56:41

CANCELLATION NO SHOW AGREEMENT

Patient Agreement

At Balance Hormone Center, we do our best to get our patients seen in a timely fashion. In return, we ask that you show up on time for your appointment. If you show up more than 10 minutes past your appointment time, you will be forced to reschedule. We do understand there are times you may need to reschedule your office visit/ procedure. If you cancel/reschedule your visit with sufficient notice, this allows us to fit other patients in that may need to be seen for their health concerns.

Effective November 1, 2023
If you have an appointment for an office visit (New patient or Follow up visit), in order to avoid a cancellation charge, you must cancel your appointment at least 24 hours/ 1 business day prior to your appointment time. This means if your appointment is scheduled on a Monday it would need to be canceled no later than Friday. Otherwise, you will incur a $25 charge. If you do not show for your appointment or show up past your scheduled appointment time, including the grace period listed above, you will incur a No Show fee of $40.

I have read, understood and agreed to the agreement described above.

E-Signature (name or initials)
Ch