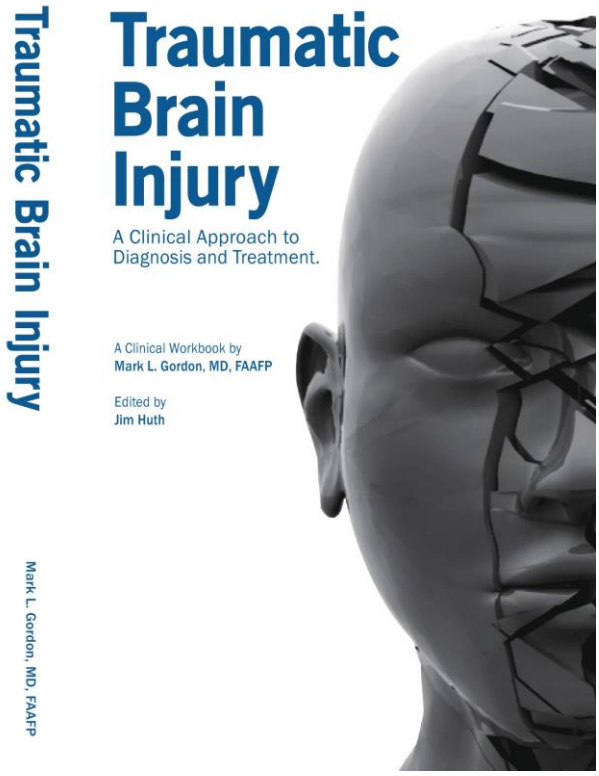
Millennium TBI Network

Rebuilding Hope one day at a time



NEW PATIENT INFORMATION PACKET – CIVILIAN TBI

GENERAL TBI ENROLLMENT PACKET 2018.6

WELCOME

You have identified yourself as an individual seeking enrollment into our Traumatic Brain Injury program. This short packet contains the most important documents needed to start your evaluation. Once you have completed this packet please email it back to sverchere@millennium-tbi-tx.com

: Dr. Sherien Verchere

: Millennium TBI Houston

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Instructions for Non-Service Personnel Enrollment Packet

This **Enrollment Packet** consist of documents needed to establish a medical record based upon knowledge of your medical history (past and present) which will be used to write up your consultation and laboratory report and to provide a customized treatment protocol. **These documents can be filled out on screen and then saved to your computer before attaching to an email or faxing to our office**. In the future, we may provide you with additional documents.

The first page following these instructions is an Out of State Disclosure form. This lets you know that we need to have a physician in your state to write any of the prescription medications we recommend. We are presently training physicians in other states to provide assessment for TBI. Please make sure that you put your name on each space that asks for it and fill out the Enrollment Packet to the best of your ability.

A credit card authorization form is included which needs to be completed for us to open your case and to arrange for your blood draw. We are a cash only facility and do not have an insurance department. No charges will be placed on your Credit Card until a member of our office calls you and answers your questions. Only after you agree to enter the program will the charges be made so we can start your program by ordering labs.

At the end of the packet is an "INFORMED CONSENT FOR THE USE OF TELEMEDICINE". This will allow us to communicate phone.com in order to provide a Physical-Patient Interaction that is LIVE but virtual. Otherwise, you will be required to come into the office.

The remaining documents are import medical history and mental health questionnaires. These will act as a record of your baseline which will be assessed repetitively throughout your treatment protocol. You will also fill out a" **History of Injury**" report. If there have been multiple traumas or injuries in the past please indicate them in the "**Summation of Injuries"**, and only fully report on the case(s) under litigation. Please be as concise as possible.

Finally, please go to our website www.tbimedlegal.com website to obtain answers and information on the most commonly asked questions or requested information. If you cannot find the answers, please email the office in lieu of calling. Once you have submitted your completed Enrollment Packet, someone in the office will call you at which time you can clarify any issues. Please be advised that there is a waiting list and backlog of patients requesting services. We are trying to minimize waiting time so if your Enrollment Packet is complete, we can accept you into the program more rapidly. Present waiting time is about 2 weeks .

Email and Fax to us:

sverchere@millennium-tbi-tx.com or FAX _____

I look forward to reviewing your results with you soon.

All the best

Dr.Sherien Verchere

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Dear Pending Patient,

Thank you for your interest in our services for Symptomatic Traumatic Brain Injury (aka PTS/PTSD).

I am one of a growing number of healthcare providers who has recognized that the traditional approach to treatment for the psychological and cognitive effects precipitated by TBI are not working. In fact, they have been responsible for worsening the multitude of symptoms associated with TBI (PTSD).

Since 2004, Dr. Mark L. Gordon of the Millennium Health Centers, Inc., in Los Angeles California has been working on a solution. He has developed a highly unique and specific laboratory test panel using readily available test but differs in the means of interpretation of the results. This has lead to the inclusion of more people into treatment than previously, and the results speak for themselves.

In 2015, Dr. Gordon started sharing his knowledge in his publication of Traumatic Brain Injury – A Clinical Approach to Diagnosis and Treatment. He subsequently started teaching other healthcare providers in the use of this information to provide you with a newer diagnostic and treatment option.

To date, over 2000 individuals have experienced an improvement in their quality of life with many getting off the medication that was creating more harm than good.

I decided to join Dr. Gordon to spread the good-will of his work to more people around the country. In order to obtain my certification, I attended classes, read, and took an extensive examination. Only upon successfully completing each phase was I certified by The Millennium-TBI Project to participate in the Millennium-TBI Network. I have also been accepted to participate with our Veterans within the Millennium-Warrior Angels Foundation (www.WAFTBI.Org) to help our traumatized veterans.

Although I am an independent provider of these services, I am also part of a revolutionary network of healthcare providers who want to Make the Difference by Being the Difference. Consider completing your Enrollment Packet and experience that difference.

All the best

Dr. Sherien Verchere

Millennium TBI Network

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What is included in our programs?

Thank you for your coming to our website to learn more about the programs that we have addressing the many faces of Symptomatic Traumatic Brain Injury often mislabeled as PTSD. Our programs have been used to diagnose and treat individuals with cognitive and psychological conditions that have not responded well to traditional medical interventions. We believe that this is due to the fact that what is assumed to be "psychological" is really a bio-chemical condition that is based upon inflammation. This inflammation appears to alter chemical pathways that allow us to make brain hormones and neurotransmitters that support our thinking and emotions. Disruption of these important pathways, well, creates all the negative changes.

What you get with your initial Enrollment into a program:

1) A phone call from our office to answer your questions before a program fee is accepted.
2) Once you agree to our program, the fees are charged so that we might arrange for your blood work to be obtained. Once we place the requisition for your labs, the ball is in the Laboratory's hands and they will contact you, send you a blood draw kit to take to one of their draw centers located closest to you. If you would prefer to have someone come to your house or office, there is an additional $35.00 charge. Let us know at this time.
3) After the blood is drawn it is shipped to the lab in Florida for processing. Once the results are completed they are sent to the Millennium to be entered into a report template. At that point the physician reviews your enrollment packet and writes the analysis of your labs and suggests a treatment protocol.
4) A copy of the report is sent to you with instructions to call the office to arrange for a 60-minute consultation; in the office, by phone .
5) When you have your consultation, you will review the lab results and learn how these bio-markers can influence your well-being. It is the intention of this process to help you understand what is going on so that you can take more control of your health. Near the end of the consult you will receive a review of each component of the treatment protocol by the healthcare provider or a support staff. Ask questions please.
6) Upon completion of the consultation, a final report will be prepared with a copy of your lab results and if available, a 60-page Patient Handbook containing supportive information including much of what was shared with you during the consultation along with medical articles. You will also be offered from the office the treatment protocol that was discussed, but you can get them on your own too.

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Your full name (F M L)	
Street Address1	
Street Address 2	
City	
State and Zip	
Contact Phone #	
Contact Email	
Your Credit Card Type	___AMEX ___VISA ___MasterCard ___Discover
Credit Card Number	
Expiration Date	
CVV or Code on back	
Credit Card Zip Code	
***Standard TBI Evaluation**	☒ $ 2500

I authorize _Dr. Sherien Verchere, MD_____ and or their representative to charge my credit card in the amount indicated above based upon the program I have selected (marked).

Digital Signature: DATE:

Once your Enrollment Packet has been submitted to the office it will be reviewed for enrollment in the program you have selected. Only after we contact you will the card be charged and the laboratory services ordered for your initial evaluation.

Additional Comments:

Contact:

Confidential Health Questionnaire

DATE:

Personal Information

Millennium-TBI Project @ www.TBImedlegal.com

First Name:	Last Name:	Age:	Gender:
Social Security Number: DO NOT ENTER	Date of Birth:	Marital Status:	Refferal Source:
Street Address:	Zip Code:	City:	State:
Best Contact Phone Number:	2nd Best Contact Phone Number:		
E-mail Address:	Preferred Method of Contact:	✔ if Ok to Leave Message: ☐ Phone ☐ Email	

Medical History

Please check any medical condition or health problem that you and your family currently have or have had in the past.

Medical Condition	Self		Family	
	Yes	No	Yes	No
Heart Attack				
Angina (Chest Pain)				
Palpitations				
Irregular Heart Rhythm				
Heart Failure (CHF)				
Heart Valve disorder				
Stroke				
Transient Ischemic Attack				
Vascular Disease				
Blood Clotting Problems				
Bleeding Disorder				
High Blood Pressure				
Diabetes Mellitus (DM)				
High Blood Sugar (100-125)				
Abnormal Cholesterol				
Obesity/Overweight				
Thyroid Disorder				
Shortness of Breath				
Asthma				
COPD				
Chronic Bronchitis				
Lung/Breathing Problems				
Sleep Apnea				
Pulmonary Hypertension				
Seizure Disorder				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Insomnia				
Dementia				
Liver Disease				
Gallbladder disease/stones				
Ulcers				
Colitis				
Chronic Constipation				
Chronic Diarrhea				
Kidney Disease or stones				
Chronic Indigestion				
GERD (Reflux Disease)				
Osteopenia or Osteoporosis				
Osteoarthritis				
Rheumatoid Arthritis				
Gout				
Chronic Muscle/Joint Pain				
Neck Pain				
Shoulder Problems				
Back Pain/Sciatica				
Herniated Disc				
Fibromyalgia				
Chronic Pain				
Tendonitis				
Cancer				
Recurrent sinus infections				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Migraines or Headaches				
Dizziness				
Loss of Consciousness				
Depression				
Anxiety				
Eating Disorder				
Emotional/Psychiatric Illness				
Alcohol Abuse				
Drug Abuse				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Seasonal Allergies				
Eczema				
Psoriasis				
Skin Problems				
Sexual/Libido Problems				
Prostate Problems				
Reproduction Problems				
Sexually Transmitted Dx				

☐ Check if you and your family do not have any other medical conditions or health problems other than those listed above.

List any other medical conditions or health problems not listed above that you and your family currently have or have had in the past.

1)	2)	3)
4)	5)	6)

Please give detail of all PERSONAL medical conditions and health problems.

☐ Check if you do not have any medical problems

Medical Condition	Date of Diagnosis	Description
1)		
2)		
3)		
4)		

Please give detail of all FAMILY medical conditions and health problems.

☐ Check if there is no family history of medical problems

Medical Condition	Relation	Date of Diagnosis	Description
1)			
2)			
3)			
4)			

Allergies to Medications ☐ Check if No Known Drug Allergies

Medication Name	Reaction
1)	
2)	

Allergies to anything else (food, environmental, latex, etc.)

☐ Check if you don't have allergies

Allergy to:	Reaction
1)	
2)	

Please list prescription medications currently being used.

☐ Check if you are not using prescription medications

Medication Name	Dosage and Frequency	Date Started	Reason for Use
1)			
2)			
3)			
4)			

Please list prescription medications used in the last year which you are no longer using. Start with the medications which were most recently stopped.

☐ Check if you haven't used prescription medications in the past

Medication Name	Dosage and Frequency	Date Started	Date Stopped	Reason Used
1)				
2)				
3)				
4)				

Please list supplements and over-the-counter medications currently being used.

☐ Check if you are not using supplements and over-the-counter medications

Medication Name	Dosage and Frequency	Date Started	Reason for Use
1)			
2)			
3)			
4)			

Please list all past SURGERIES.

☐ Check if you have not had surgery in the past

Surgery	Date of Surgery	Reason for Surgery
1)		
2)		
3)		
4)		

Personal & Social History.

Occupation:	Employer:	Stress Level at Work (10=highest)	Describe Work Stressors:
Marital Status:	# Living Children:	Stress Level at Home (10=highest)	Describe Home Stressors:

Use of Alcohol: ☐ Yes ☐ No	Type of Alcohol:	Amount:	Start Date:	Stop Date:	Duration:
Tobacco: ☐ Yes ☐ No	Cigarettes/day:	Other Tobacco:	Start Date:	Stop Date:	Duration:

Street Drug Use: ☐ Yes ☐ No	Type of Drug:	Amount:	Start Date:	Stop Date:	Duration:
Sexually Active: ☐ Yes ☐ No	Sexuality:	# of Partners:	Unprotected Sex: ☐ Yes ☐ No	Contraception:	Duration:
Hobbies/Interests:					

OB/Gyn History (Female patients)			
Last Menstrual Period:	Age During Onset of 1st Period:	PMS Symptoms: ☐ Yes ☐ No	Cycle Duration:
Check if you have any of the following: ☐ Heavy Bleeding ☐ Spotting ☐ Pain ☐ Irregularity		Describe:	

Are you pregnant: ☐ Yes ☐ No	Are you breastfeeding: ☐ Yes ☐ No	Are you trying for a pregnancy: ☐ Yes ☐ No			
# of Pregnancies:	Vaginal:	C-section:	Miscarriages:	Abortions:	Other Complications:

Review of Systems

Please check YES to any symptom that you experience. For any YES answer please provide a brief description

Symptoms	No	Yes	If YES, List Doctor Seen, Describe Condition and How Long
Fever/Chills	☐	☐	
Execess Fatigue	☐	☐	
Weight Loss/Gain	☐	☐	
Enlarged Lymph Nodes	☐	☐	
Frequent Bruising	☐	☐	
Blurry Vision	☐	☐	
Ringing in Ears	☐	☐	
Hearing Difficulty	☐	☐	
Mouth Sores	☐	☐	
Sinus Problems	☐	☐	
Cardiovascular:	**No**	**Yes**	
Chest Pain at Rest or Exercise	☐	☐	
Cold hands/Cold Feet	☐	☐	
Swelling of Legs	☐	☐	
Gastrointestinal:	**No**	**Yes**	**# Bowel Movement /Day**
Constipation	☐	☐	
Diarrhea	☐	☐	
Bloating	☐	☐	
Exessive Belching	☐	☐	
Gas/Acidity	☐	☐	
Blood in Stool	☐	☐	
Thirst: Lack of /Too Much	☐	☐	**# Glasses of Fluid/Day**
Genitourinary:	**No**	**Yes**	
Pain on Urination	☐	☐	
Cloudy/Bloody Urination	☐	☐	
Urinating Too Many Times	☐	☐	**# Times per Day**
Difficulty Urinating	☐	☐	
Loos of Urine	☐	☐	

Musculoskeletal:	No	Yes	If YES. please Rank PAIN Severity
Do you see a Chiropractor?	☐	☐	
Any Regular Body Treatment Massage?	☐	☐	
Back Pain	☐	☐	
Neck Pain	☐	☐	
Shoulder Pain	☐	☐	
Arm Pain	☐	☐	
Hip Pain	☐	☐	
Knee Pain	☐	☐	
Other pain	☐	☐	
Muscle Point Tenderness (pls. Describe)	☐	☐	
Skin:	**No**	**Yes**	
Acne	☐	☐	
Dry Skin	☐	☐	
Oily skin	☐	☐	
Loss of Collagen/Firmness	☐	☐	
Wrinkles	☐	☐	
Pigmentation/Scarring	☐	☐	
Any History of Skin Cancer?	☐	☐	
Do you Wear Sunblock?	☐	☐	
After Sun Exposure, Do you (Check):	☐ Burn	☐ Sometimes Burn	☐ Rarely Burn ☐ Never Burn ☐ Tan
Cellulite	☐	☐	
Questions on Aesthetic Services: Botox, Juvederm or Lasers?	☐	☐	
Interest in Skin Care Consultation?	☐	☐	
Emotional:	**No**	**Yes**	
Do you See Counselor or Psychiatrist?	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Stress	☐	☐	
Please List any other Complaints			Please List Doctors Seen, Sescribe Condition and How Long
1)			
2)			
3)			

FEMALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Loss of energy/fatigue				
Loss of sex drive/orgasm				
Fat gain				
Muscle weakness/loss				
Difficulty Sleeping				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swings				
Decline in Memory				
Decline in Concentration				
Hot Flashes				
Night Sweats				
Vaginal Dryness				

FEMALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Vaginal Dryness				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hair				
Hair Loss				
Muscle and Joint Paint				
Loss of Pubic Hair				
Food Cravings				
Sugar Cravings				
Salt Cravings				
List any other Symptoms				
1)				
2)				
3)				

MALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Loss of Energy/Fatigue				
Loss of Motivation				
Loss of Confidence				
Loss of Sex Drive/Orgasm				
Difficulty Maintaining Erection				
Difficulty Achieving Erection				
Premature Ejaculation				
Fat Gain				
Muscle Weakness/Loss				
Difficulty Sleeping				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swing				
Decline in Memory				
Decline in Concentration				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hari				
Hair Loss				
Muscle and Joint Pain				
Loss of Pubic Hair				
Food Cravings				
Sugar Cravings				
Salt Cravings				
List any other Symptoms				
1)				
2)				
3)				

Your signature below attests that you have been truthful and have completed this health questionnaire to the best of your ability.

Signature: _____

Print Name: _____

Date: _____

Male/Female Irritability Index

Hormonal Imbalances in the brain can cause symptoms that can present in one or more of the following manners; Please check off accordingly with 0 = Never, 1 = 25%, 2= 50%, 3= 75% and 4 = 100% of the time.

Name: **Date:**

How often do you feel :	**0**	**1**	**2**	**3**	**4**	**Comments**
1. Angry						
2. Fatigued						
3. Impatient						
4. Blaming						
5. Dissatisfied						
6. Moody/Grumpy						
7. Fearful						
8. Discontented						
9. Hypersensitive/Easily Annoyed						
10. Mentally exhausted						
11. Bored						
12. Aggressive						
13. Unloved						
14. Unappreciated						
15. Tense (anxious)						
16. Touchy						
17. Unloving						
18. Lonely						
19. Hostile						
20. Overwhelmed						
21. Destructive						
22. Demanding						
23. Frustrated						
24. Withdrawn/detached						
25. Mean						
26. Sad (depressed feeling)						
27. Scared						
28. Numb/insensitive						
29. Explosive						
30. Defensive						
31. Denies Problems						
32. Self-Critical						
33. Troubled						
34. Desire to Over-eat						
35. Drug or Alcohol Use.						
36. Excitable						
37. Withdrawn into TV						
38. Overworked						
39. Sleep more						
40. Impulsive						
41. Worried						
42. Argumentative						
43. Sarcastic						
44. Jealous						
45. Uncommunicative						

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Medication and Supplement Lists

Anyone that is taking more than 4 prescription or/or supplements, please use the space below to register them. In general, I am not a good supporter of an excessive number of medications nor supplements. Regarding any prescribed medication, it will be your responsibility to discuss modifications to their use with the healthcare provider that dispensed them to you. AS for your existing supplementation, we use a very specific grouping of supplements to obtain our results. This is not to say that what you are presently using, upon entry into the Millennium-TBI Program, is useful or not. It is more to say less is better. The chances that we will ask you to stop other non-essential supplements is very HIGH.

Finally, do not alter any of your medications or supplements prior to having your blood work performed, especially pro-hormones and hormones. This can cause a misreading of the results and that is why you are receiving this document. ***Past Medication**: Those that you used within 6 months of your blood test but were taken off of if prior to the blood testing.

Name: Date:

Present Medication	Dose and Frequency	Present Medication	Dose and Frequency
***Past Medication**	Dose and Frequency	*Past Medication	Dose and Frequency
Supplement	**Dose and Frequency**	**Supplement**	**Dose and Frequency**

Thank You

Dr.

Sherien Verchere

Return this document with your Enrollment pack if included or if received after your enrollment packet was submitted to : _____

Traumatic Brain Injury - Neurosteroid Deficiency Syndrome

A developing area in Hormone Replacement Strategies is the relationship between any form of head trauma and hormone deficiencies. Therefore, please answer the following:

Name **Date of exam**

Please check off any of these activities that you participated in or experienced.

√	Activities	YRS	√	Activities	YRS	√	Activities	YRS
	Boxing			Break dancing			Soccer	
	Wrestling /Grappling			Extreme Sports			Rugby	
	Track and Field			Water or Snow Skiing			Basketball	
	Gymnastics			Skate boarding			Football	
	Martial Arts/MMA			Dirt Bikes / Motocross			Baseball	
	Snow Boarding			Stock Car Racing			Roller Coasters	
	Automobile Accident			Motorcycle Accident			Bicycle Accident	
	Slip and Fall			Explosion (IED)			Repetitive gun fire	
	Pneumatic Tools			Parachutist			Artillary	

Injures related to any of the above activities. LOC means Loss Of Consciousness

Type of Injury	Age	Year	LOC	Hom	ER	Hos	Duration/Comment	GCS

Relative to the head injures above have you experience any of the following?

√	Symptoms	Intensity	√	Symptoms	Intensity
☐	Decrease in Recent Memory	1 2 3 4 5	☐	Lack of Interest in life/Bored	1 2 3 4 5
☐	Decrease in Remote Memory	1 2 3 4 5	☐	Lack of sex drive (libido)	1 2 3 4 5
☐	Lack of Concentration (focus)	1 2 3 4 5	☐	Lack of competitiveness	1 2 3 4 5
☐	Periods of Disorientation	1 2 3 4 5	☐	Lack of confidence	1 2 3 4 5
☐	Mood swings	1 2 3 4 5	☐	Sleeping more (hypersomnia)	1 2 3 4 5
☐	Sudden out-bursts of Anger	1 2 3 4 5	☐	On-set of Insomnia.	1 2 3 4 5
☐	Sudden Irritability	1 2 3 4 5	☐	Change in Sense of Smell	1 2 3 4 5
☐	Depression	1 2 3 4 5	☐	Change in Vision	1 2 3 4 5
☐	Self Isolation	1 2 3 4 5	☐	Anxiety (panic attacks)	1 2 3 4 5
☐	Recurrent Headaches/Migraines	1 2 3 4 5	☐	Change in Menses (Periods)	1 2 3 4 5
☐	Decrease in intelligence	1 2 3 4 5	☐	Increase in Tiredness or fatigued	1 2 3 4 5

Please fill this form out with the physician.

T:_____ LOC:_____ Hosp:_____

TBI Specific Event Reporting Form

Name Today's Date

*Please fill out one of these **TBI Reporting Forms** for up to 3 of the most significant traumas that you sustained.*

This event happened in (year) _____, as a ☐Civilian, ☐ Soldier, ☐Law Enforcement, ☐Other_____, when I was _____ years old:

	Car Accident (MVA)		Blast Trauma		Gun Fire		Slip n Fall		Stroke		Assault
	Motorcycle (MCA)		IED		Sports (any)		Cannon Noise		Jet engines		Shot Gun
	Bicycle (BCA)		Fall from object		Contact Sport		Martial Arts		Parachute		Surgery
	Football		Rugby		Soccer		Lacrosse		Jujitsu		MMA
	Wrestling		Grappling								

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting ____ seconds/minutes/hours/days/weeks.
2. With this injury I ☐Was NOT ☐Was in a Coma for ____hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale ____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	☐ Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

TBI Specific Event Reporting Form

Name Today's Date

*Please fill out one of these **TBI Reporting Forms** for up to 3 of the most significant traumas that you sustained.*

This event happened in (year) _____, as a ☐Civilian, ☐ Soldier, ☐Law Enforcement, ☐Other_____, when I was _____ years old:

	Car Accident (MVA)		Blast Trauma		Gun Fire		Slip n Fall		Stroke		Assault
	Motorcycle (MCA)		IED		Sports (any)		Cannon Noise		Jet engines		Shot Gun
	Bicycle (BCA)		Fall from object		Contact Sport		Martial Arts		Parachute		Surgery
	Football		Rugby		Soccer		Lacrosse		Jujitsu		MMA
	Wrestling		Grappling								

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting ____ seconds/minutes/hours/days/weeks.
2. With this injury I ☐Was NOT ☐Was in a Coma for ____hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale ____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	☐ Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

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Guarantee of Results

Medical Care for Symptomatic TBI

I, _____, have had the opportunity to discuss the potential benefits and risks of a treatment protocol using hormone replacement and a selective supplementation protocol with my physician: [x] Dr. Sherien Verchere

It is my clear understanding that there are no guarantees as to the ultimate outcome and benefits that I personally will glean from returning my hormones to a more physiological level, improving upon my dietary nutrition, and by performing an appropriate exercise program.

I understand that results are absolutely individualize and vary from person to person and that my chances of having the results that I am looking for (Patient Goals form) will be based upon the following:

1. Adhering to the nutritional supplementation, dietary recommendations, and hormonal replacement strategies as directed by the physician;
2. Following the timing of the recommended office visits with laboratory testing;
3. Using each and every product, in the timing and quantity as directed by the physician.

Each of these parameters has been reviewed with my physicians and an appointment schedule has/will been/be provided in my Patient's Handbook.

It is my full understanding that the chances of obtaining the outcome that I am looking for is greatest when I follow these recommendations although; I was never given a guaranteed.

I have read this statement and understand and accept the potentiality that I will not have the results that I am looking to obtain*.

Printed Name Signature Date

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Notice of HIPAA Guidelines.

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your periodical medical reports:

I wish to be contacted in the following manner(s):
(Check off all that apply)

√	Home Phone:	√	Mobile Phone:
☐	Leave message with detailed information here.	☐	Leave message with detailed information here.
☐	Leave message with callback number only.	☐	Leave message with callback number only.
	Email Report	☐	Written Communications
☐	Leave message with detailed information here.	☐	Please continue to send to my home
☐	Send all reports by email when they are available.	☐	
	I also authorize you to be able to speak with my physicians or family member listed here:		
☐		☐	
☐		☐	
		☐	

Patient's Signature and Date

Printed Name and Date of Birth

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Consent to Medical Care and Treatment

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned treatment. You have received over one hour of specific education regarding the proposed hormonal treatment based upon your assessment. We have reviewed benefits and risks. You have had an opportunity to ask questions and to request additional information.

I authorize Sherien Verchere **, M.D.** and such physicians, associates, assistants and other personnel of the Millennium Health Group chosen by him or her to perform the following**:**
Hormonal Assessment and Treatment, and/or to do any other procedure that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to obtain the maximal benefits with the least risks in regards to the above proposed program of hormonal replacement therapy.

[___] GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment, which have been described and I have discussed with the doctor.

[___] SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this treatment protocol/program as described by the doctor which included: Risks of breast and prostate cancer in association with the use of Testosterone, Estrogens and Growth Hormone. Weight gain, increased muscular mass, decreased body fat, hair growth, change in hair color, hypoglycemia, disclosure of latent diabetes, transient fluid retention, carpal tunnel syndrome, transient joint pain, headaches, and death.

[___] ALTERNATIVE TREATMENT: I am satisfied with my understanding of alternative treatments and their possible benefits and risks including: **Testosterone Injections, Oral Estrogen/Progesterone replacement, Topical Testosterone, Estrogen, Progesterone replacement or sublingual Testosterone replacement, Isoflavones, Vitamin and mineral replacement.**

[___] NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

[___] SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment from another physician with credentials from the A4M or any physician of my choosing.

[___] LIMITATION OF MEDICAL CARE: I understand that the Millennium Health Groups' doctor (MHG doctor) is providing a specific hormonal treatment and protocol and that he/she is not taking responsibility for any other aspect of my ongoing medical health. **My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize the doctor to speak directly with my Primary Care physician when medically necessary regarding my past and present medical care and treatment.**

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the treatment and all of my additional questions about the treatment have been answered.

Signature:_____Date:_____Time_____AM/PM

Primary Physician:_____Telephone#:_____

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Medical Services Agreement (MediCare)

_____(PATIENT) and _____ (PHYSICIAN) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT acknowledges and agrees that this agreement has been entered into before the PHYSICIAN has provided the services specified herein to the PATIENT.

2. The Millennium Health Group and its PHYSICIANS are only responsible for the evaluation and prescription of hormone replacement therapy when indicated by appropriate laboratory testing. All laboratory tests can be billed separately by the laboratory performing those services or else the patient May request to pay a discounted fee.

3. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.

4. The services to be provided to the PATIENT consist of performing diagnostic tests and providing assessment of their chemical and hormonal status. All laboratory tests have an interpretation fee and report fee added to their cost.

5. **[ ]* The PATIENT agrees not to request that a health insurance claim form be submitted in their behalf under the Social Security Act (MEDICARE) for the services, even if such services are otherwise covered under health insurance or MEDICARE.**

6. **The PATIENT agrees to be responsible for the SERVICES.** Although hormone replacement therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or anti-aging/hormone-balancing replacement therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General take the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government. Even though the use of human growth hormone in adults has been approved by the Food and Drug Administration, it has not been recognized by the Federal Government as "medically necessary" and therefore, could, be interpreted as fraudulent.

7. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provided reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a-1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.

8. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.

9. **[ ]* By signing this agreement, the PATIENT understands that they are foregoing their rights to receive insurance/MEDICARE benefits for the SERVICES, but that PATIENT is not forfeiting all health insurance benefits for other services from other health insurance/MEDICARE providers.**

Patient's Signature Date: _____

Physician Signature Date: _____

Witness Signature Date: _____

***** An additional MediCare Contract will be needed for any person who is receiving any financial assistance from MediCare or is of age to receive benefits from MediCare.**

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Private Contract (MediCare Only)

This agreement is between _____whose principal place of business is _____, and:

Beneficiary: _____

Who resides at: _____

Medicare ID #: _____

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 on August 1, 2001 for a period of at least two years, to expire on July 31, 2003. 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:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge 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 to Medicare 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 physicians 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 that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

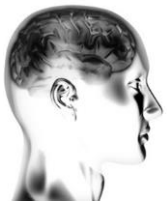
_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

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

Executed on:_____

By(patient): _____ And Sherien Verchere

Beneficiary or his/her legal representative M.D.



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Reimbursement of Testimony and Subpoena Costs

After reviewing literature on your services involving the diagnosis and treatment of hormone related dysfunction, secondary to neurotrauma, I would like to be evaluated to determine if I am suffering from symptoms caused by a previous or recent injury. You have informed me that you will not agree to accept my case unless I agree to reimburse you for certain expenses that may result from participation in the evaluation of my case; (i.e. personal injury, social security claim, disability claim, insurance claim, etc.).

This document acknowledges that you are not being retained as an expert witness or will be used as one, but that your services for me are as a physician and care giver.

I understand that the evaluation of my case and myself may cause you to be called upon either voluntarily or by subpoena to testify or provide evidence regarding your evaluation (reports, copies of medical records, etc.). I understand that in so doing, you will expend time and incur costs in preparing to give testimony, giving testimony, preparing and producing documentation and possibly retaining counsel to assist you. Therefore I agree as follows:

1. I agree not to designate you as an expert witness in my medical case.
2. I agree that if you are required to either voluntarily or by subpoena to testify or provide evidence regarding your evaluation I shall compensate you with the following amounts which shall be in addition to your standard fees in your capacity as my consulting physician:
    a. $500 per hour for any time spent in consulting with you or counsel;
    b. $5,000/day for any deposition or testimony I am required to provide in your case regardless of whether I am testifying voluntarily or subject to subpoena.
    c. Reimbursement for Business Class travel, hotel accommodations and food.
3. All payments and travel arrangements shall me paid and arranged in advance.
4. I shall reimburse you reasonable attorneys' fees if you determine it necessary to retain your own counsel to represent you.

By signing below I agree to the above referenced terms.

Name: _____

Signature: _____ Date: _____

If you are actively involved in a legal proceeding, please have your attorney review this document and provide the following information:

_____

Attorney name, signature, contact phone number or email

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:	Date of Birth:	Medical Record:
Patient Address: City: State: Zip:		Date Consent Discussed:

Physician Name: Dr. Sherien Verchere	Location: 6575 West Loop South, Suite #500, Bellaire, TX 77401
Consultant Name:	Location: 6575 West Loop South, Suite #500, Bellaire, TX 77401
Consultant Name:	Location: 6575 West Loop South, Suite #500, Bellaire, TX 77401

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Dr. Sherien Verchere (*name of Physician*) has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Dr. Sherien Verchere (*name of Physician*) of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Texas and will be present in the state of Texas during all telehealth enocounters Dr. Sherien Verchere *name of Physician*).

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Dr. Sherien Verchere (*name of Physician*) to use telemedicine in the course of my diagnosis and treatment.

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

WITNESS **DATE**

PHYSICIAN'S SIGNATURE **DATE**

I have been offered a copy of this consent form. _____ (Patient's Initials)

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us