ED
Clinics of Indiana

Patient Information

Patient Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____ / _____ / _____

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Partnered

Home Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____

Primary Number: ❒ Home ❒ Cell **Secondary Number:** ❒ Home ❒ Cell

Email Address: _____

Emergency Contact _____ **Phone Number** _____ **Relation** _____

Whom may we thank for your referral? _____

My Privacy

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by ED Clinics of Indiana to ensure the privacy of my personal health information.

Signature _____ **Date** _____

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Financial Policy

ED Clinics of Indiana offers Extracorporeal Shock Wave Therapy treatment packages based on each patient's individual needs. The number of treatments needed ranges from 6-12, depending on your other health conditions, age, how long you have experienced erectile dysfunction, and the severity of ED. Your specific course of treatment will be determined by the doctor at ED Clinics of Indiana during your first initial visit and must be paid in full prior to treatment rendered.

Consultation - $50
(If you proceed with treatment this $50 will be credited towards your treatments)

Prepaid package of 12 treatments - $3,800
Prepaid package of 6 treatments - $2,000
Prepaid package of 3 treatments - $1050
1 treatment - $370

Maintenance treatment - $300

*1-2 maintenance treatments may be recommended after treatment plan completion. Maintenance treatment prices can only be purchased 3 months after the purchase and completion of the doctor's recommended treatment plan. You may purchase up to 2 maintenance visits per year, any more will require purchase of a package.

I understand that this treatment is an elective procedure and is non-refundable. I understand that ESWT for ED treatments are not billable to my insurance and must be paid out of pocket with cash, check, or credit card. Checks can be made out to ED Clinics of Indiana.

I agree to follow the treatment plan determined by the doctor to obtain optimal results of my current condition. I understand that ESWT treatments are to be performed once a week for the duration of the time recommended by the doctor.

I understand that appointment cancellations must be made at least 24 hours in advance. A cancellation that is not made 24 hours in advance is considered a failed appointment and may be subject to a cancellation fee of $30.

Patient Signature _____ **Date** _____

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Informed Consent for Extracorporeal Shock Wave Therapy

- Erectile dysfunction caused by certain underlying health and medical conditions may not be successfully treated with ESWT. ESWT is best suited for vascular ED. I acknowledge that I have given an accurate current and previous medical health history to ED Clinics of Indiana.
- Due to the many contributing factors to ED and due to the fact that every human's body responds to medical intervention differently, there is no guarantee of success. Studies have shown that ESWT works in about 70% of men who have vascular ED.
- ED Clinics of Indiana does not, cannot, and will not diagnose erectile dysfunction. I acknowledge that ED Clinics of Indiana strongly encourages proof of diagnosis from a healthcare professional and I authorize the medical professional of ED Clinics of Indiana to treat this condition.
- I understand the purpose of the procedure to be: applied Extracorporeal Shock Wave Therapy with an FDA-cleared medical device to those areas that the medical professional believes will be most effective in optimizing sexual health and wellness.
- The number of treatments needed ranges from 6-12 depending on complicating health conditions, age, how long you have experienced erectile dysfunction, and the severity of ED.
- Although the risks of ESWT are very low, they must be listed. I understand the most common risks associated with the proposed procedure(s) to be:
    - Swelling
    - Reddening of skin
    - Soreness

  Less common risks to the proposed procedure(s) to be:
    - Hematoma (bruising)
    - Petechiae (minor broken blood vessels)
- I acknowledge that the ED Clinics of Indiana medical professional is using his/her best judgement in recommendations for treatment. I understand that there is no guarantee of outcome.
- I give my informed and voluntary consent to the proposed procedure(s). I understand that if I did not wish to accept the risks associated with this therapy, then I would choose to not sign this consent.
- By signing below, I state that I have read the contents of this form, I understand the information on this form, and I give my consent to be treated by ED Clinics of Indiana.

Patient Name _____ **Date** _____

Patient Signature _____

Clinics of Indiana

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name (print) _____ **Date Of Birth** _____

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Name of individual (parents and spouses must be added if they are to have access)	**Relationship with patient**	**Specify information allowed**
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other _____
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other _____
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other _____

ED Clinics of Indiana has my permission to: (Please check all that apply)

❒ Leave detailed message **at home** with my spouse

❒ Leave detailed message **at home** with**:** NAME: _____ Relationship: _____

❒ Leave detailed message on my **cell phone** Cell phone number: _____

❒ Leave detailed message on my **home answering machine** Home phone number: _____

❒ Leave detailed message on my **voicemail at work** Work phone number: _____

In order to obtain information by telephone, the party calling ED Clinics of Indiana must be able to confirm the patient's date of birth with the staff.

Signature _____ **Date** _____

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Health History

Patient Name: _____ **Date of Birth**: _____

Height: _____ft_____in_ **Weight**: _____

Have you been clinically diagnosed with Erectile Dysfunction? ❒ YES ❒ NO

If yes, when were you diagnosed? _____

Have you been clinically diagnosed with Peyronie's Disease? ❒ YES ❒ NO

If yes, when were you diagnosed?

❒ Less than 6 months ago ❒ Between 6-12 months ❒ More than 12 months ago

Check any of the following conditions that you currently have or have had in the past:

❒ Alcohol Use
❒ Atherosclerosis
❒ Chronic Pelvic Pain Syndrome (Prostatitis)
❒ Cigarette Use
❒ Depression
❒ Diabetes
❒ Drug Use
❒ Enlarged Prostate
❒ Heart Disease
❒ High Blood Pressure
❒ High Cholesterol
❒ Multiple Sclerosis
❒ Obesity
❒ Pacemaker
❒ Parkinson's Disease
❒ Prostate Cancer
❒ Radical Prostatectomy
❒ Relationship Stress

Other health conditions or medical history: _____

Do you currently take PDE5i (phosphodiesterase type 5 inhibitors) (Ex. Viagra or Cialis)? ❒ YES ❒ NO

If yes, what and how often? _____

PDE5i Response: ❒ None ❒ Poor ❒ Good

List all medications you currently take:

_____ _____ _____

_____ _____ _____

Medication allergies: ❒NONE ❒Penicillin ❒Codeine ❒Sulfa drugs ❒Other _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of ED Clinics of Indiana staff responsible for any errors or omission that I may have made in the completion of this form.

Patient Signature _____ **Date** _____

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Sexual Health Inventory for Men (SHIM)

Patient Name _____ **Date** _____

Over the past 6 months:

1. How do you rate your confidence that you could keep an erection?

--Select--

2. During erections with sexual stimulation, how often are your erections hard enough for penetration?

--Select--

3. During sexual intercourse, how often are you able to maintain your erection after you penetrate?

--Select--

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse?

--Select--

5. When you attempt sexual intercourse, how often is it satisfactory for you?

--Select--

- - - - - -

The Erectile Hardness Score (EHS): *CHECK ONE*

- ☐ Penis does not enlarge
- ☐ Penis is larger, but not hard
- ☐ Penis is hard, but not hard enough for penetration
- ☐ Penis is hard enough for penetration, but not completely hard
- ☐ Penis is completely hard and fully rigid