ED
Clinics of Indiana

# Patient Information

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

**Date of Birth** _____ / _____ / _____ **Marital Status:** --Select--

**Home Address** _____ **Apt #** _____

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

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

**Primary Number:** ☐ Home ☐ Cell **Secondary Number:** ☐ Home ☐ Cell

Please note: text and email reminders are sent with minimal personal information. These messages are sent securely with our software, but once it reaches your phone it is only as safe as you and your phone company's security.

**Please check which source you would prefer for your reminders.**

☐ **Text appointment reminders**

☐ **Emailed appointment reminders** **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 APWT treatment packages based on each patient's individual needs. Your specific course of treatment will be determined by your doctor at ED Clinics of Indiana during your first initial visit and must be paid in full prior to treatments rendered.

6 treatments - $3,210
1 treatment - $595
Maintenance treatment - $400
(available after purchase of a package)

I understand that APWT for ED treatments are **not** billable to my insurance and must be paid out of pocket with cash, check, or credit card.

I agree to follow the treatment plan determined by the doctor to obtain optimal results of my current condition. I understand that APTW treatments are to be performed once a week for the duration of the time recommended by the doctor. These treatments will be scheduled at the time of package payment.

I understand that APWT for ED appointment cancellations must be made 24 hours in advanced. A cancellation that is not made 24 hours in advance is considered a failed appointment. **I understand that 3 failed appointments during the calendar year will incur a $25 charge.**

**Patient Name** _____ **Date** _____

**Patient Signature** _____

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# Informed Consent for Acoustic Pressure Wave Therapy

ED Clinics of Indiana does not, cannot, and will not diagnose Erectile Dysfunction (ED). Recipients of Acoustic Pressure Wave Therapy (APWT) for ED are required to speak with their healthcare professional and provide proof of diagnosis prior to treatment.

- I acknowledge that I have received either written or verbal information about my condition from my healthcare professional and I have received information about the proposed treatment from ED Clinics of Indiana. I authorize the medical professional(s) of ED Clinics of Indiana to treat my condition.

- I understand the purpose of the therapy procedure(s) to be: applied APWT with an FDA cleared medical device to those areas that the medical professional(s) believes will be most effective in optimizing sexual health and wellness.

- Although APWT treatments have been performed on thousands of patients and the risks 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)

- The ED Clinics of Indiana medical professional is using his/her best judgement in recommendations for treatment and 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 am 18 years of age or older. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to be treated by ED Clinics of Indiana.

**Patient Name** _____ **Date** _____

**Patient Signature** _____

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# 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<br>❒ May check balances<br>❒ Full access<br>❒ Other _____ |
| | | ❒ Appointment information<br>❒ May check balances<br>❒ Full access<br>❒ Other _____ |
| | | ❒ Appointment information<br>❒ May check balances<br>❒ Full access<br>❒ 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**: _____ lbs.

**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?** --Select--

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

- ❒ Heart Disease
- ❒ Pacemaker
- ❒ Diabetes
- ❒ Atherosclerosis
- ❒ Enlarged Prostate
- ❒ Radical Prostatectomy
- ❒ Parkinson's Disease
- ❒ Multiple Sclerosis
- ❒ High Cholesterol
- ❒ Chronic Pelvis Pain Syndrome (Prostatitis)
- ❒ High Blood Pressure
- ❒ Obesity
- ❒ Alcoholism
- ❒ Prostate Cancer

**Other 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:** --Select--

**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