FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

Patient Authorization for Delivery of Medications

I, _____, hereby authorize the clinic staff on duty to act on my behalf to accept medication delivery from the clinics dispensing physician and deliver my medications and refills to me as prescribed by my provider.

I understand that the provider is not responsible for lost or damaged good and all issues regarding mail delivery shall be handled through the mailing company used.

I understand that I may be required to come to the office to accept delivery of such medications from the staff on duty on a weekly basis (or as often as ordered by the physician). This authorization will remain active for the course of my treatment at this clinic or until I revoke it in writing.

No Guarantee of Services

Florida Alternative Medicine and Weight Loss does not guarantee that any services or medications will be provided to you until you have undergone the full preliminary sign up process and physician's examination.

At the physician's discretion you will be provided medications and/or services during your program at Florida Alternative Medicine and Weight Loss.

No Refund Policy

*Florida Alternative Medicine and Weight Loss LLC reserves the right to have NO RETURN and NO REFUND policy.

_____

Patient Signature

Informed Consent for Hormone Replacement Therapy

Because of the rapidly changing ideas about the safety and effectiveness of hormone therapy for anything other than birth control, I feel it is important to be sure that you have information about the risks and benefits of hormone therapy before you take the therapy we have discussed. HRT is approved by the FDA for prescribed deficiencies only. Using it for other symptoms or problems is considered “off-label” use and the liability is on the patient not the doctor. When hormone levels are brought back to “normal” for your age there is much evidence that your overall health will benefit. HRT is the most effective treatment for hormone deficiencies. There may be other long-term beneficial effects of treatment. The medical frame of mind is always changing so it is important to discuss HRT with your doctor each year at your annual exam to find out what the latest information is.

Please read the following and sign: I have discussed the reason for taking female/male sex hormones with my provider. I understand why he/she is prescribing them and the risks associated with taking hormones including but not limited to the possibility of an increased risk of breast or endometrial cancer, blood clotting, stroke, or heart attack. I understand that there are different risks if I take any HRT medication. I have discussed these risks and the reasons for taking them, with my doctor. I understand that my provider will do everything he/she knows to do to decrease and minimize the risks of HRT. I understand that there are no guarantees that these measures will be effective at preventing the negative side effects mentioned above or others that we do not yet know about. I accept the risks and unknowns of taking hormone therapy and wish to have my provider prescribe them for me.

_____ _____

Name (please print) Date of Birth

_____ _____

Signature of patient Date

FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

MEDICAL HISTORY AND SCREENING FORM

General Information

Participant:

*please write legibly as this information is used to complete your patient chart

First Name _____ Middle Initial _____ Last Name _____

Date of Birth (month) _____ / (day) _____ / (year) _____

Phone Number _____ Alternate Number _____

Email _____

Street Address _____

City _____ State _____ Zip _____

Ethnicity ☐ American Indian or Alaskan Native ☐ Hispanic or Latino ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ Patient Declined ☐ Other _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other_____ Phone _____

Address _____ City _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

What is/are your purpose(s) for participating in the HRT program?

☐ To determine my current level of health and to receive a possible recommendation for an HRT program.
☐ Other (please explain): _____
_____
_____

Current Medical History

Check those questions to which you answer yes. Leave all others blank.

☐ Has a doctor ever said your blood pressure was too high?
☐ Do you ever have pain in your chest or heart?
☐ Are you often bothered by a thumping of the heart?
☐ Does your heart often race?
☐ Do you ever notice extra heartbeats or skipped beats?
☐ Are your ankles often abnormally swollen?
☐ Do cold hands or feet trouble you even in hot weather?
☐ Has a doctor ever said that you have had heart trouble, an abnormal echocardiogram or EKG, heart attack or coronary?
☐ Do you suffer from frequent cramps in your legs?
☐ Do you often have difficulty breathing?
☐ Do you get out of breath long before anyone else?
☐ Do you sometimes get out of breath when sitting or sleeping?
☐ Has a doctor ever told you that your cholesterol level was high?
☐ Has a doctor ever told you that you have an abdominal aortic aneurism?
☐ Has a doctor ever told you that you have a critical aortic stenosis?

Comments: _____
_____
_____

Do you now have or have you recently experienced?

☐ chronic, recurrent or morning cough?
☐ episodes of coughing up blood?
☐ increased anxiety or depression?
☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
☐ migraine or recurrent headaches?
☐ swollen or painful knees or ankles?
☐ swollen, stiff or painful joints?
☐ pain in your legs after walking short distances?
☐ foot problems?
☐ back problems?
☐ stomach or intestinal problems such as recurrent heartburn, ulcers, constipation or diarrhea?
☐ significant vision or hearing problems?

- ☐ recent change in a wart or mole?
- ☐ glaucoma or increased pressure in the eyes?
- ☐ exposure to long noises for long periods?
- ☐ an infection such as pneumonia followed by fever?
- ☐ significant unexplained weight loss?
- ☐ a fever which can cause dehydration and rapid heartbeat?
- ☐ a deep vein thrombosis (blood clot)?
- ☐ a hernia that is causing symptoms?
- ☐ foot or ankle sores that won't heal?
- ☐ persistent pain or problems walking after you have fallen?
- ☐ eye symptoms such as bleeding the retina or detached retina?
- ☐ cataract or lens transplant?
- ☐ laser treatment or another eye surgery?

Comments: _____
_____
_____

Women only answer the following. Do you have:

- ☐ menstrual period problems?
- ☐ significant childbirth related problems?
- ☐ urine loss when you cough, sneeze or laugh?

Date of last pelvic exam and/or PAP smear: _____

Are you on any type of hormone replacement therapy? ☐ Yes ☐ No

Comments: _____
_____
_____

Men and Women, both, answer the following.

List any prescription medications you are now taking: _____
_____
_____

List any self-prescribed medications, dietary supplements or vitamins you are now taking: _____
_____
_____

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't Remember

Date of last chest x-ray: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't Remember

Date of last echocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't Remember

Date of last dental exam: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't Remember

List any medical or diagnostic testing you have had in the last two years: _____

_____

_____

List hospitalizations including dates of and reasons for hospitalizations: _____

_____

_____

List all allergies to drugs: _____

_____

_____

Past Medical History

Check those questions to which you answer yes. Leave all others blank.

☐	Heart attack. If so, how long ago? _____	☐	Rheumatic fever
☐	Heart murmur	☐	Diseases of the arteries
☐	Varicose veins	☐	Arthritis of the legs or arms
☐	Diabetes or abnormal blood sugar tests	☐	Phlebitis (inflammation of a vein)
☐	Dizziness or fainting spells	☐	Epilepsy or seizures
☐	Stroke	☐	Diphtheria
☐	Scarlet fever	☐	Nervous or emotional problems
☐	Infectious mononucleosis	☐	Heart attack
☐	Thyroid problems	☐	Anemia
☐	Pneumonia	☐	Abnormal chest x-ray
☐	Asthma	☐	Other lung disease
☐	Bronchitis	☐	Injuries to back, legs, arms or joints
☐	Jaundice or gallbladder problems	☐	Broken bones

Comments: _____

_____

FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

CREDIT CARD AUTHORIZATION FORM

CARD TYPE: __ Master Card __ VISA __ Discover __ AMEX

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME ON CARD: _____

AUTHORIZED SIGNATURE: _____

By signing this form, you give Florida Alternative Medicine and Weight Loss permission to keep the above credit card on file and charge it for future orders. The card on file can be changed prior to your next transaction. You are authorizing Florida Alternative Medicine and Weight Loss to charge and sign your card for future transactions using SQUARE.

*__Florida Alternative Medicine and Weight Loss LLC__ reserves the right to have NO RETURN and NO REFUND policy.

**All orders will be processed once the payment clears. Please allow 5-7 business days for all orders to be processed.

Please email back this form to: INFO@flalternativemeds.com

Future orders can be placed at: ORDERS@flalternativemeds.com