FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

Patient Authorization for Delivery of Medications

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

I understand that delivery of such medications can be picked up at the clinic or mailed to my provided address 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.

Any orders delivered damaged or incomplete must be reported to Florida Alternative Medicine; referred to as FAM within 24 hours of delivery and the pictures of damaged package / product must be sent to INFO@flalternativemeds.com. FAM is not financially responsible or liable for lost or stolen items once delivered. Once items have been scanned as delivered to the customer's address, it is up to the customer to report any missing or stolen packages to FAM within 24 hours of delivery date. It is up to the customer to have the FedEx Mobile App to receive step by step updates during the shipping process. Any packages returned for an INCOMPLETE/ INCORRECT address can be shipped again at the patient's expense.

No Guarantee of Services

FAM does not guarantee that any services or medications will be provided to you until you have undergone the full initial sign-up process and physician's examination.

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

You're required to have an annual consultation and lab work done through FAM. Lab work every 6 months is preferred but not required. Additional lab work can be requested by the provider at any time. You, as the patient, take full financial responsibility for your lab order should you decide to use your personal health insurance instead of utilizing the office cash-pay program. FAM is not liable for any future bills you may incur for said lab work if you decide to use your personal health insurance to do said labs.

No Refund Policy

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

By signing below, I understand all company policies as outlined above and agree to abide by them to their fullest extent:

_____ _____

Patient's Name (please print) Date of Birth

_____ _____

Patient's Signature Today's Date

FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

HIPAA - Patient Consent of Information

Florida Alternative Medicine, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Florida Alternative Medicine from violating the patient' s confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Florida Alternative Medicine physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Florida Alternative Medicine staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ via text message
_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with_____relationship_____
_____ with_____relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

_____ _____

Patient's Name (please print) Date of Birth

_____ _____

Patient's Signature Today's Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Florida Alternative Medicine Practice.

_____I have declined a copy of Florida Alternative Medicine Notice of Privacy Practice.

_____ _____

Patient's Signature Date

FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

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 only for prescribed deficiencies. 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 benefits. 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 male/female sex hormones with my doctor and 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 this risk and the reasons for taking them with my doctor. I understand that my doctor will do everything he/she knows to do to decrease and minimize the risks of HRT but 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 doctor prescribe them for me.

_____ _____

Patient’s Name (please print) Date of Birth

_____ _____

Patient’s Signature Today’s 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) _____

Current Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

*** Any future address change must be submitted in writing to INFO@flalternativemeds.com

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: _____ State: ___ Zip Code: _____

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

☐ Yes ☐ No

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

What is (are) your purpose (s) for participation in this HRT Program?

- ☐ To determine my current level of health and to receive recommendations for an HRT program.
- ☐ Other (please explain) _____

_____
_____
_____
_____

Present Medical History

Check those questions to which you answer yes (leave the 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 badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG 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 still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ **Has a doctor ever told you that you have an abdominal aortic aneurysm?**
- ☐ **Has a doctor ever told you that you have critical aortic stenosis?**

Comments: _____
_____
_____
_____

Do you now have or have you recently experienced:

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode 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 a mole?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ An infection such as pneumonia accompanied by a 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 conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other 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 the last pelvic exam and / or Pap smear _____

Comments: _____

_____

_____

_____

Are you currently on any type of hormone replacement therapy?

Men and women 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 electrocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental checkup: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

List any other medical or diagnostic test you have had in the past two years: _____

_____

_____

List hospitalizations, including dates of and reasons for hospitalization: _____

_____

_____

List any drug allergies: _____

_____

_____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of 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
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems

Comments: _____

_____

Hormone Health:

Check the box that pertains to you:

- ☐ Waking up in the morning not feeling refreshed and well rested
- ☐ Feeling like I need to take a nap in the middle of the day
- ☐ Needing to rely on caffeine or other stimulants
- ☐ Not getting an adequate full night's sleep
- ☐ Recent changes in your sex drive
- ☐ Difficulty with sexual arousal
- ☐ Changes in your enjoyment of life or loss of motivation
- ☐ Weight changes or difficulty maintaining your weight
- ☐ Recent difficulty managing your stress
- ☐ Past diagnoses of any hormone related condition

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

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

Future re-orders can be placed at: ORDERS@flalternativemeds.com. Once the email has been received, our office staff member will reach out to you to confirm the re-order and collect the payment.

FLORIDA ALTERNATIVE MEDICINE AND WEIGHT LOSS, LLC

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.

➢ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ ***See pages 3 & 4*** *for more information on uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	•You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	•You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. •We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	•You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include· all the disclosures, except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make) We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the privacy notice receive the notice electronically. We will provide you with a paper copy promptly
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can ad for you before we take any action
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201,calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ • We will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a dear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friend or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.*
In these cases, we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways

Treat you	We can use your health information and share it with other professionals who are treating you.	**Example**: *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve your care and contact you when necessary.	**Example**: *We use health information about you to manage your treatment and services.*
Bill for your services	We can use your health information and share it with other professionals who are treating you.	**Example**: *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do Research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing If you tell us we can, you may change your mind at any time Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacylhipaalunderstanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective: January 1, 2021

This Notice of Privacy Practices applies to the following organizations

This notice applies to Florida Alternative Medicine