FLORIDA CENTER FOR
HORMONES & WELLNESS

Welcome! I am honored that you have chosen the Florida Center for Hormones and Wellness as your partner in your journey toward wellness. My team and I are committed to making your experience with us enjoyable, rewarding and most importantly, health improving. I am sure that you will quickly see that my office is very different that most other medical offices in terms of the conditions we deal with, my treatment philosophy, my commitment to excellence and the time that we spend with our patients. Most importantly, I want you to feel that we are paying attention to your health and wellness needs and treating you as the most important member of the wellness team.

Despite our very unique type and style of practice, there are still a number of standard things that we must do in order to properly prepare you for your visit and to make sure that we are accumulating the data and information necessary to legally and ethically provide medical care.
I do need to ask you to fill out a number of standard forms. While I would absolutely love to eliminate most of them, I am legally required to collect some of this information and to inform you of some things regarding your medical care and the use of your private data and information.

If you are coming into the office for a routine age-related hormone evaluation, it would be best, easiest and most respectful of your time if we had the necessary blood work at the initial visit. Of course, if you prefer, you can schedule an appointment with me before your blood work if you feel that that your particular situation requires an evaluation before blood work is done. Additionally, in some of the more complex age-management, hormone and weight loss situations, I may ask that you come in first so that I can properly compose a blood test panel that is more appropriately tailored to your particular needs.

BLOODWORK:

If you need to have your blood work completed prior to your first visit, please make sure that you have it drawn at least 7 days in advance so that it will be completed by the lab prior to your arrival. In this packet are 3 lab requisitions: one for Quest Diagnostics, one for LabCorp and a generic lab requisition if your insurance requires you to use aa lab other than those two. My office is able to draw blood for most labs, so if it is more convenient, you can always book a blood draw appointment in this office. Please remember, you should fast for at least 8 hours prior to you blood draw and it is best to get your blood drawn before 9:00am.

There are countless insurance rules covering blood work. Unfortunately, my staff does not know them and cannot give you any advice as to what your co-payment or deductibles might be, so it is your responsibility to know exactly what your insurance will or will not cover.
I prefer that you go directly to Quest or LabCorp to get your labs drawn with the requisitions contained in this packet. We have found that when patients go to their primary care doctors, since they are unfamiliar with the evaluation requirements of this type of practice they frequently do not order the proper selection of lab tests. When this happens, it might be necessary to either have you re-schedule or go to the lab for a second round of blood draws.
If your Insurance does not cover the cost of your labs; if you have a high deductible or co-payment of if you just simply want to be completely "self-pay" I have arranged to have a very "low cost"

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cash price in the office. I have been able to get very favorable pricing from a private lab. This allows me to provide my patients a usual hormone evaluation panel for only $275. Many times this price is even below the deductible on many Insurance Plans. If you would like to take advantage of that option:

- Contact my office at (407) 507-3837 to let my staff know you would like to take advantage of this option. The office is open M-Th from 9-5 and on Friday from 9-2.
- Notify the receptionist that you would like to schedule an appointment to have your blood work done and that you would like to take advantage of our low priced labs.

COMPLETING THE PAPERWORK:

One thing that you will notice in my office is that I work very hard to run on time. You will not sit waiting in my office, something that happens far too often in most other office. To help me stay on schedule, **EITHER YOU MUST COMPLETE YOUR PAPERWORK PRIOR TO YOUR ARRIVAL OR YOU MUST SHOW UP AT LEAST 30 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME SO THAT YOU HAVE TIME TO COMPLETE YOUR PAPERWORK**. Out of respect for the patients that follow your appointment, if your paperwork is not complete by the time your appointment is scheduled to begin, my staff may be forced to re-schedule your appointment.

Please read and complete all the paperwork that pertains to your health history and all of the forms that pertain to your demographic information, Privacy Practices and Communications and email. Beyond those forms, at a minimum, please read and review all of the consent forms so that you are familiar with their contents. This will allow you to formulate any questions that you might have. If you are comfortable signing them, go right ahead. If you want to discuss their contents, you will have plenty of opportunity to do so, either with my staff or with me.

RETURNING THE PAPERWORK:

It would be best if you fax or email the completed paperwork to the office in advance of your visit. That way, once you arrive, you will be ready to go and this will help minimize any waiting time before we get to meet. **Our fax number is: (407) 507-3841 and the direct email is** admin@hormonesandwellness.com.

SCHEDULING YOUR APPOINTMENT:

Once we receive ALL of your information, your paperwork and in many cases your lab work, someone from my staff will contact you to set up your initial consultation.

Again, I am honored that you have chosen me as your wellness provider and I eagerly look forward to meeting you and helping you get started on your road to wellness.

Sincerely,

John C Carrozzella, MD, MSMS

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PERSONAL PROFILE

First/Last Name _____

Gender ☐ Male ☐ Female Date of Birth _____ / _____ / _____

Address _____

City/State _____ Zip Code_____

Phone: Home (____) _____ Work (_____) _____ Cell (_____) _____
Which phone number may we use to leave messages? O Home O Work O Cell O None

E-mail _____

Marital Status: O Single O Married O Separated O Divorced O Widowed

Emergency Contact _____

Occupation_____ Hours per week _____

O Retired O Stay-home O Unemployed O Self-employed

Employer _____

Insurance Provider _____

Primary Care Physician _____ Phone _____
Do you want us to send your notes to your PCP? O Yes O No

How did you hear about Florida Center for Hormones and Wellness? _____

Medical Information
Please bring copies of current (within past 2 years) medical reports and laboratory tests to your appointment.

Date of last medical or health care visit _____ /_____/ _____ Date of last physical exam _____ /_____ / ____

Date of last laboratory testing _____ / _____ /_____

_____

_____

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_____

_____

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For Males Only

Date of last testicular exam _____ Results _____

Date of last digital rectal exam (prostate exam) _____
Results _____

Date of last prostate specific antigen (PSA) blood test _____
Results _____

Are you sexually active? O Yes O No. Current form of contraception _____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss? _____

For Females Only

Date of last OB/GYN exam _____

Last PAP _____ Results _____

Have you ever had an abnormal PAP? O Yes O No. If Yes, describe _____

Date of last mammogram _____ Results_____

Date of last manual breast exam (performed by physician) _____ Results_____

Are you sexually active? O Yes O No Current form of contraception _____

Have you ever used birth control pills? o Yes o No. If Yes, for how long _____ Type _____

Side effects of birth control pills, if any_____

Have you ever used an IUD? O Yes O No. If Yes, for how long? Type of IUD _____

Age of first menstruation _____

Did you have a difficult time during puberty (i.e., physically, emotionally)? O Yes O No

If Yes, explain_____

_____

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Cont. Female Only

If you experience PMS (Premenstrual Syndrome), please check the following symptoms that apply:

PMT-A	**PMT-D**	**PMT-C**	**PMT-H**
O Nervous tension	O Depression	O Headache	O Weight gain
O Irritability	O Forgetful	O Cravings for sweets	O Bloating
O Mood changes	O Crying	O Increased appetite	O Swelling of extremities
O Anxiety	O Confusion	O Heart pounding	O Breast tenderness
O Insomnia	O Dizziness or faint	O Cramping	O Fatigue

Periods occur every _____ days (e.g., 28 days) Do you ever skip periods? O Yes O No

Are your periods consistent (occur the same time each month)? O Yes O No

Date of last period: _____

Periods usually last _____ days on average (e.g., 5 days). Quantity of flow: O Light O Moderate O Heavy

Number of tampons and/or pads used per day: _____ tampons _____ pads

Quality of menstrual blood: o Dark red o Bright red o Large clots Describe: _____

Are you currently pregnant? O Yes O No

Pregnancies (include current) _____ # Births _____ # Miscarriages _____ # Abortions _____

Any complications with pregnancy? O Yes O No. If Yes, please explain _____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss? _____

_____

_____

Have you reached: O Peri-menopause O Menopause O Post-menopause?

Have you or are you taking hormone replacement therapy? O Yes O No. Duration of use _____
(If on BHRT - bring current prescription with you)

Type of hormone replacement therapy _____ Dose _____ (i.e., milligrams per day)

Have you had a hysterectomy? O Yes O No If Yes: O Partial O Complete
Have you had a uterine ablation? O Yes O No Date _____

_____

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Childhood/Adolescence History

How was your health as a child? O Excellent O Good (typical illnesses) O Chronically Ill

Were you troubled by: O Acne O Allergies O Asthma O Eczema O Fatigue O Chronic Bronchitis

O Chronic Ear Infections O Chronic Sore Throats O Stomach Problems O Depression

O Learning/Behavioral Problems O Other Chronic Infections: _____

O Other:_____

List all medication(s) used for an extended period of time (e.g., antibiotics, cortisone, etc.)? _____

_____

Were you overweight as a child/adolescent? O Yes O No

How would you describe your experience of childhood/adolescence: O Happy/Secure O Lonely

O Stressed/Pressured O Deprived of Love/Affection O Abused: O Verbally O Physically O Sexually

_____

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_____

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_____

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Weight Concerns / Health Concerns – PRINT AS MANY OF THIS PAGES NECESSARY

Please list your Weight/Health concerns. Begin with the most important. Write a brief chronological history of our concerns on a separate page.

_____

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Print and fill out a separate page for each medical concern you want to discuss with Doctor.

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Medications - List prescription and over-the-counter drugs you are currently taking or have previously taken for extended periods of time (greater than a month). Please bring your medications to your appointment.

Drugs Name	Reason for Taking	Dose (mg/day)	Date Started	Date Discontinued	Side Effects

Please list allergies to medications: _____

_____

_____

Nutritional Supplements - Examples: Vitamin, minerals, herbal & Homeopathic remedies

For evaluation of content and quality please bring supplements to your appointment

Name /Type	Reason for Taking	Dose	Date Started	Results/Benefits

_____

_____

_____

_____

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Hospitalization, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure/Admission	Outcome/Results

Family History – Use the key below to identify family members and their associated health conditions. Please list type where parentheses are present.

M: Mother F: Father S: Sister B: Brother G: Grandparents A: Aunt U: Uncle C: Child

Condition	Relative	Condition	Relative
Allergies		Eczema	
Alcoholism		Epilepsy	
Anemia		Gout	
Alzheimer's		Heart Disease	
Arthritis (Rheumatoid)		High Blood Pressure	
Arthritis (Osteo)		High Cholesterol	
Asthma		Kidney Disease	
Bleeding Disorder		Lupus	
Cancer ( )		Mental Disorder	
Cancer ( )		Nervous System Disease	
Celiac Disease		Obesity	
Cohn's Disease		Stroke	
Colitis		Thyroid (Hypo/Hyper)	
Depression		Other ( )	
Diabetes Type 1		Other ( )	
Diabetes Type 2		Other ( )	

_____

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Personal Habits – Substance Use

	Tobacco	Alcohol	Caffeine	Drugs
Currently Use				
Previously Used				
Never Used				
How much/many per day/week/month				
Specify Type: (cigarettes/cigars/ pipe/chewing tobacco; beer/wine/ spirits; tea/coffee/espresso/soft drinks/ energy drinks/ weight loss products; cocaine/marijuana/ heroin/ ecstasy)				
Duration of use (month/years)				
Date Quit				

Exercise (Complete this section only if you exercise regularly)

Type of exercise (biking, walking, yoga, jogging, weights, swimming)	**How long per session** (minutes, hours)	**Frequency** (daily, weekly)	**How long have you been doing this specific activity** (week, month, years)

Sleep

Hours per night _____

Do you have trouble falling asleep? o Yes o No If Yes, what keeps you up? _____

Do you have trouble staying asleep? o Yes o No If Yes, how many times do you wake up per night and is there a consistent time that you wake throughout the night? _____

Do you snore excessively or experience sleep apnea? o Yes o No

Do you have any recurring dreams? o Yes o No If Yes, please describe _____

_____

Do you wake refreshed? o Yes o No

What time do you go to bed? _____ What time do you rise in the morning? _____

_____

_____

_____

_____

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Recreation & Relaxation

How much time per day do you spend watching television? _____

How much time per day do you spend on Computers?

How much time per day do you spend outdoors?

What are our interests and hobbies?

Do you have a lot of clutter in your life? (i.e. home and/or work)? o Yes o No

What do you do for relaxation?

Do you consider yourself a "relaxed" individual? o Yes o No

Social History

What are the major sources of happiness in your life? _____

Are you presently happy with your life? o Yes o No Why or why not? _____

_____

What are the major sources of stress in your life? _____

Stress level (rate on scale of 1-10, 1=lowest stress, 10=severe, chronic stress) _____

How do you cope with stress? _____

How important is religion or spirituality in your life? _____

Do you have a good support network (friends, family, pets)? o Yes o No _____

Are you fulfilled by your work? o Yes o No If no, Why not? _____

Do you have short and long term goals for your life? o Yes o No _____

Do you take regular vacations? o Yes o No If Yes, how often and how long (per year)? _____

Is there a noticeable change in your health while on vacation? o Yes o No Describe _____

_____

Environmental History

Where do you live (e.g., house, apartment)? _____

Where do you work? _____

Has the air quality in your home, place of work been a concern to you or others? o Yes o No
If yes, explain _____

Are you exposed to any harsh chemicals at work or at home? o Yes o No
If yes, explain _____

What is the source of your drinking water? o Distilled o Filtered o Spring o Tap/City o Well

_____

_____

_____

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Allergies

Do you suffer from allergies? o Yes o No If yes, to what (e.g., pollens, grasses, dust, animals, food)?

_____

Have you ever experienced an anaphylaxis reaction, (i.e., severe allergic reaction requiring medical attention)? o Yes o No If yes, to what? _____

Have you had allergy testing? o Yes o No If yes, what type of testing (e.g., blood, skin scratch test)?

Results _____

Diet

List any specific foods or beverages you exclude from you diet and why? _____

_____

How many meals do you generally eat each day? _____

Have you "yo-yo" dieted in the past? o Yes o No Explain _____

How often do you eat our or take-out food? _____

Do you crave any specific foods or beverages (e.g., sweets, chocolate, salty snack foods, bread, soda?

o Yes o No If yes, which foods or beverages? _____

Are there specific foods that you feel you can't live without? o Yes o No if yes, which ones? _____

_____

List any foods/beverages that do not agree with you? _____

How do those foods/beverages not agree with you? _____

What type of oil do you use for cooking/baking? _____

How much water do you drink on a typical day? _____

2-Day Diet Assessment

Please list all foods and beverages consumed in the last two days.

	Day 1	Day 2
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Dessert		
Evening Snack		

_____

_____

_____

_____

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General Diet Assessment

Please check the appropriate boxes, (daily, weekly, monthly or never), to help us assess your diet.

Food Category	Daily	Weekly	Monthly	Never
Baked sweet goods (cakes, cookies, muffins, pastries, pies)				
Deep-fried foods/Harmful fats (french fries, fried chicken/fish, chips, donuts, margarine)				
Candy				
Chocolate				
Soda				
Juice/sweetened beverages / sport drinks				
Hot/cold cereal (specify type _____)				
Bread/Bagels/Rolls (specify type _____)				
Pizza				
Rice				
Potatoes				
Milk				
Cheese				
Yogurt				
Butter Ice cream				
Fruits				
Vegetables				
Eggs				
Fish				
Chicken/Turkey				
Red meat (steak, pork, bacon, sausage, hamburger, hot dogs)				
Beans/Legumes				
Soy (tofu, tempeh, miso, soy milk, edamame)				
Nuts/Seeds				
White/brown sugar, Honey				
Artificial sweeteners (Aspartame, NutraSweet, Equal, Splenda)				
Other				

Thank you for taking time to fill out this questionnaire. Please remember to bring your nutritional supplements/medications and copies of your laboratory test/medical reports to your appointment

_____ _____ _____

Print Name Signature Date

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Health Assessment for Women

Name: _____ **Date:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast Tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

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Financial Policy

The Florida Center for Hormones and Wellness (FCHW) has established the following policies for the practice. By informing our patients of these policies, we believe that there will be fewer financial misunderstandings. Please read and sign where indicated. Please let us know if you have any questions.

1. In order to make your appointment run as efficiently as possible, it is best if you arrive at least 15 minutes early if your paper work has been filled out. If you need to complete your paperwork at the time of your visit you should arrive at least 30 minutes prior to your appointment to complete the necessary paperwork. Your appointment time is a specific period of time for the physician to spend with you and only you. Your appointment time is not for filling out paperwork; it is for face to face contact with the physician.

   Regardless of the reason, you must notify us 24 hours before your scheduled appointment time if you want to cancel, change or reschedule your appointment. Missing your appointment time is disrespectful to other patients and the doctor and deprives them of valuable time. Patients who do not show prevent other patients from making appointments. Failure to be here 15 minutes before your appointment means that you are late, and literally prevents others from returning home to their friends, family and loved ones. In fairness and consideration to all of our cherished patients, we reserve the right to cancel or reschedule your appointment or to apply the following fees should you fail to notify us that you will be late for or will miss your appointment time:

   LATE FEE: $25 ($50 for repetitive cases)

   CANCELLATION FEE – NO SHOW FEE: $50 (or forfeiture of deposit – whichever is greater)

   A Late Fee will be assessed and the patient may be re-scheduled (at the doctor's sole discretion) once a patient is 5 minutes late for their scheduled appointment as determined by the clock at the receptionist desk. Please be advised that these rates may go up for those who habitually miss their appointment time. Missing your appointment time (Late or No Show) more than three times may result in fee of $100 per occurrence (or forfeiture of your deposit) and/or may be grounds for the patient being discharged from the practice. This fee is not covered by your insurance. This fee must be paid on or before your next scheduled appointment.

2. Payment is expected at the time of your visit. We will accept cash or most credit/debit cards. Unfortunately, we do not accept checks at this time.

3. Presently, we only accept assignment and are contracted with the Insurance companies that follow. This is a voluntary business decision. We do not participate in the Medicare or the Medicaid programs
   a. Tri-Care

4. For patients with insurance coverage in which we are contracted providers, payment for patient's cost share (co-payments, co-insurance, deductible amounts and outstanding balances) is normally due at the time of service unless other arrangements are made. If a balance remains after your insurance(s) processes your claim, you will be asked to pay the balance at your next office visit or you may receive a bill from our billing agency. This balance is payable upon receipt of your bill. If your balance becomes delinquent (over 60 days old from your last visit), our office may pursue outside intervention in order to collect any monies owed to us. To prevent this from occurring it is important that you contact either our office or our billing agency if you have questions regarding your balance.

   If your account were to become delinquent and unaddressed, our office would release the minimal amount of information required in order to secure payment.

5. For patients with Insurance coverage but who are receiving services that are not considered covered or that are not considered medically necessary by their Insurance company will be required to pay for those services at the time of service or make other arrangements with this office (such as financing).

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6. For patients with insurance coverage in which we are not contracted providers:
    a. Payment for the full amount of the day's service is due at the time of service unless other arrangements are made. If the patient desires, following the visit, we will submit a claim to the Insurance Company on the behalf of the Insured. Should the claim be returned for further re-work, this office will process only one further re-work of the claim. Any further re-work of the claim, will be the responsibility of the Insured or his representative. This office will not re-work any claims, beyond the first rework, unless contracted to do so by the Insured or his representative as outlined below in Section 8.

    b. This office will not accept any assignment of benefits. Upon filing of claims, we will designate that all payments be sent directly to the Insured. Should any payment from the Insurance Company be received by this office, it will either be sent to the Insured or it will be returned to the Insurance Company.

    c. Once a claim is submitted to the Insurance Company, there are be a number of possible outcomes for that claim. It may be (all possibilities may not be noted below):
        i. Accepted and paid, in which the patient may receive a payment in an amount that is determined by the Insurance Company. Please be advised that the amount the Insurance Company pays **MAY NOT BE** the full amount that has been billed. Any difference remains the responsibility of the Insured or the Patient. This office will not discount fees to the amount allowable by the Insurance Company.

        ii. Accepted and applied to the Deductible. In this case, the patient may receive either a reduced payment or no payment at all from their Insurance Company, depending upon the amount of deductible remaining on the Insured's plan at the time the claim is submitted. The full fee for services rendered remains the responsibility of the Insured or the Patient.

        iii. Accepted and applied to the Co-payment. In this case, the patient may receive either a reduced payment or no payment at all from their Insurance Company, depending upon the terms of the Insured's plan at the time the claim is submitted. The full fee for services rendered remains the responsibility of the Insured or the Patient.

        iv. Accepted and applied to the Co-insurance. In this case, the patient may receive either a reduced payment or no payment at all from their Insurance Company, depending upon the terms of the Insured's plan at the time the claim is submitted. The full fee for services rendered remains the responsibility of the Insured or the Patient.

        v. Denied for more information. In this case, this office will provide the requested information as explained in section 6a. This will be considered the one re-work of the claim.

        vi. Denied as Not-Covered or as Not-Medically Necessary. In this case the full fee for services rendered remains the responsibility of the Insured or the Patient.

7. FCHW and its billing agent will do their best to make sure that all claims requested by the Patient or the Insured to be filed through our system will be filed in a timely manner Upon request, FCHW or its billing agent will produce for the Insured evidence that the claim has been filed in a timely manner. It is the responsibility of the Patient or the Insured to be sure that the claims have been received by and processed by the Insurance Company as it is not uncommon for claims to be properly filed by FCHW or its billing agent and then misplaced by the Insurance Company. Since FCHW and its billing agent may not receive an Explanation of Medical

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Benefits (EOB) nor will we maintain an accounts receivable for billed services, we will have no way to determine whether or if a claim has been received, adjudicated or paid by the Insurance company. The Patient and the Insured agrees to hold FCHW and its billing company harmless for any and all failures in the insurance submission, adjudication and payment process other than the timely filing of a claim. In any event, FCHW will not be responsible for any claim that goes unpaid and is not brought to our attention within 60 days of the date of service

8. As noted in Section 6a above, any further re-work of claims beyond the first rework, will be the responsibility of the Patient, the Insured or his representative. Should the Patient, the Insured or his representative desire assistance in this process, FCHW will be available to assist on a contracted basis. The fee for this assistance will be $50 per hour worked (with a minimum of 30 minutes or $25) whether in face to face discussion with the Patient, the Insured or his representative or in communication with the billing agent, the Insurance Company or any other entity necessary to effect a proper adjudication of the claim. In order for FCHW to undertake this contracting endeavor, the Patient, the Insured or his representative must agree to this contract in writing and place a credit card on file for the billing of the fees associated with this execution of the contract. Should the Patient or the Insured require direct contact with the billing agent, the patient may be charged an hourly assistance fee at their current hourly rate for client interaction.
9. FCHW will file claims to any Secondary Insurance Company upon request. The fee to file these claims will be $10.00 and will be subject to the same policy as for filing to the primary insurance policy as outlined in sections 5 through 8 above
10. For patients without insurance coverage, full payment is due at the time of service.
11. Our financial office is available for consultations on payment plans. In the unlikely event that your account would be turned over to our collection agency due to non-compliance of payment plan agreements/seriously past due amounts, patients or guarantors will be responsible for all outstanding balances, regardless of the type of treatment, procedure or sale, in addition to a 25% collection fee charged to us by the collection agency. Future appointments cannot be scheduled until these balances are paid in full by cash or credit card. Accounts that are forwarded to our collection agency may be reported to the credit bureau and may impact your credit record/rating.
12. Reproduction of Medical Records: For patients and governmental agencies requesting copies of medical records, the fees charged shall be $1.00 per page for the first 25 pages and the $0.25 for each page thereafter. For all other entities, copying charges shall be $1.00 per page. Payment for reproduction shall be made in advance of the copies being produced. Postage for mailing may be an additional charge.
13. Letters, Forms and Special Reports: The fee for completion of simple forms and letters will be $25 per page. Special Reports will start at $100 and shall be charged commensurate with the work required to complete the report.

By signing below, I acknowledge that I have read and understand the above Financial Policy, and that I agree to the terms which are listed above

Print Name: _____ Signature _____

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FLORIDA CENTER FOR
HORMONES & WELLNESS

General Statement of Fees

Initial Hormone Evaluation (approx. 30-45 minute visit)	$275.00
Hormone Programs – FEMALE	
PELLETS	Optional Payment Plan **(Startup Fee) $495**
Advanced Wellness $2700	$225.00 month
Hormones Only $1800	$150.00 month
CREAMS	Optional Payment Plan **(Startup Fee) $395**
Advanced Wellness $2700	$200.00 month
Hormones Only $1800	$125.00 month
CAPSULES	Optional Payment Plan **(Startup Fee) $395**
Advanced Wellness $2700	$205.00 month
Hormones Only $1800	$130.00 month
Hormone Programs – MALE	
PELLETS	Optional Payment Plan **(Startup Fee) $595**
Advanced Wellness $2940	$245.00 month
Hormones Only $2130	$177.50 month
CREAMS	Optional Payment Plan **(Startup Fee) $595**
Advanced Wellness $2940	$200.00 month
Hormones Only $2130	$175.00 month
INJECTION	Optional Payment Plan **(Startup Fee) $595**
Advanced Wellness $2940	$170.00 month
Hormones Only $2130	$135.00 month
Separate Hormone Charges	
Blood Work (lab)	$450 (covers 12 months)
Extra PELLETS	Female $250 Male $450
Thyroid	$275
Progesterone	$465
Testosterone Injection	$105 + Shipping (per vial)

NOTE: If patient enters any Hormone Wellness Program within 15 days of initial evaluation, initial consultation fee will be applied to entry fee or to the annual program.

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Consent for Bio-identical Hormone Therapy in Women

Background:

You have been diagnosed with or have an increased risk of having a hormone deficiency (ies) and your doctor has recommended treatment with bio-identical hormone replacement therapy (BHRT). Many bio-Identical hormone preparations that include estrogen and progesterone are indeed approved for human use by the FDA, however some of the bio-identical hormone compounds that may be prescribed for you may or may not be regulated and or specifically approved by the FDA or by the pharmacy compounding law. The use of this therapy as it relates to your diagnosis, while common in Age Management, Wellness and other non-traditional medical practices, may be considered controversial in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard treatments to be used so that you make an informed decision whether or not to undergo the treatments after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may have the information needed to give or withhold your consent to the proposed treatment plan.

At least one alternative may be the use of specific nutritional supplements and other hormonal therapies. Alternative therapies as such may lessen or eliminate the risks of hormone therapy, but these alternatives may or may not be as effective in the treatment of your condition. Of course, not taking the therapy is an alternative that may eliminate any risk of complications or side effects that are specifically related to the therapy. However, not taking the therapy will do nothing to reduce or eliminate any of the age-related disease risks that are attendant to any hormone imbalance

Informed Consent:

- I understand that this prescription for Hormonal Therapy is indicated for the treatment of the symptoms of Female Sex Hormone Deficiency, sometimes called Menopause, based upon my medical history, physical findings and laboratory tests.
- I understand that the treating health care provider cannot guarantee any positive results or that there will be no side effects or harm. The goal and potential benefit of this therapy is to prevent, reduce or control the symptomatic dysfunction that occurs as a result of hormone deficiency or the aging process and the low hormone production that occurs in aging females.
- Bio-identical hormone therapy is available in various forms including pills, capsules, sublingual drops, troches, topical creams, pellets and injection.
- I understand that the typical side effects associated with the use of estrogen and/or progesterone may include but are not limited to uterine bleeding, fluid retention, swelling of the ankles, breast and nipple tenderness, irritability, depression, headaches, aggravation of migraines, impaired glucose metabolism, and weight gain.
- I have been informed that estrogen or estrogen-progestin preparations have been given a “black box warning” by the FDA. I have also been informed that the treating health care provider, based upon his interpretation of the existing medical literature concerning bio-identical hormone therapy, strongly disagrees with the FDA “black Box” warning. The current text of the black box warning reads as follows:
- WARNING: ENDOMETRIAL CANCER, CARDIOVASCULAR DISORDERS, BREAST CANCER AND PROBABLE DEMENTIA

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- Estrogen-Alone Therapy:
    - There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens
    - Estrogen-alone therapy should not be used for the prevention of cardiovascular disease or dementia
    - The Women's Health Initiative (WHI) estrogen-alone sub study reported increased risks of stroke and deep vein thrombosis (DVT)
    - The WHI Memory Study (WHIMS) estrogen-alone ancillary study of WHI reported an increased risk of probable dementia in postmenopausal woman 65 years of age and older
- Estrogen Plus Progestin Therapy:
    - Estrogen plus progestin therapy should not be used for the prevention of cardiovascular disease or dementia
    - The WHI estrogen plus progestin substudy reported increased risks of stroke, DVT, pulmonary embolism (PE), and myocardial infarction (MI)
    - The WHI estrogen plus progestin substudy reported increased risks of invasive breast cancer
    - The WHIMS estrogen plus progestin ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older
- I have been advised by the treating health care provider that combination bio-identical estrogen and progesterone therapy has substantial medical literature in support of the improvement of women's health and, longevity. It is the opinion of the treating heath care provider that the medical literature strongly contradicts the FDA "black box" warning. Specifically, there is medical evidence to suggest that combination bio-identical estrogen and progesterone therapy:
    - Reduces the risk of coronary artery and other cardiovascular diseases
    - Reduces the risk of osteoporosis and the risk of death from osteoporosis related fractures
    - Reduces the risk of age related dementias and Alzheimer's disease
    - Reduces the risk of macular degeneration
    - Reduces the risk of colon cancer and other certain female cancers
    - Reduces the risk of "all-cause mortality"; meaning that women who are hormone balanced live longer lives
    - Reduces the risk of or improves the symptoms of genital atrophy and sexual responsiveness
    - Reduces the effects of age related/hormone mediated psychogenic symptoms
    - Improves lipid metabolism
    - Improves Glucose/sugar metabolism and reduces the risk of type 2 diabetes
    - Provides a more beneficial hormonal environment for weight management

Initials MD: _____ / Pt: _____

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- Estrogen therapy may be but is not absolutely contraindicated in women with a history of the following: breast or uterine cancer, phlebitis, blood clots, bleeding problems, gall bladder disease, uterine fibroma, and liver disease. However, there is no conclusive medical evidence that bio-identical hormone therapy causes any of these serious health conditions.
- I understand that the typical side effects associated with the use of progesterone therapy may include but are not limited to breast and nipple tenderness, drowsiness, slight dizziness, water retention, anxiety, difficulty sleeping, depression, acne, rashes, hot flashes, appetite increases and weight gain.
- I have been advised that the FDA does not recognize an indication for the use of testosterone in women and that any such use would be considered "off label".
- The FDA has issues several warnings governing the use of testosterone. These warnings have been issued regarding the use of testosterone in men, but have been "transferred" to the use of women, often without any medical evidence to support these advisories and warnings. The current warnings about testosterone include:
- TESTOSTERONE WARNINGS AND PRECAUTIONS:
    - Increase in the hemoglobin and hematocrit. Sometimes referred to (incorrectly) as Polycythemia.
    - Venous blood clots and thromboembolism
    - Cardiovascular risk
    - Hepatic risk
    - Edema
    - Sleep Apnea
    - Adverse change in lipid profile
    - Decrease in Thyroid Binding Globulin
- I have been advised by the treating health care provider that bio-identical testosterone therapy has substantial medical literature in support of the improvement of women's health and longevity. It is the opinion of the treating heath care provider that the medical literature strongly contradicts the FDA warnings about the use of testosterone in women. Specifically, there is medical evidence to suggest that bio-identical testosterone therapy:
    - Reduces the risk of coronary artery and other cardiovascular diseases
    - Reduces the risk of osteoporosis and the risk of death from osteoporosis related fractures
    - Reduces the risk of age related dementias and Alzheimer's disease
    - Reduces the risk of macular degeneration
    - Reduces the risk of breast cancer
    - Reduces the risk of colon cancer and other certain female cancers
    - Reduces the risk of "all-cause mortality"; meaning that women who are hormone balanced live longer lives

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- Reduces the risk of or improves the symptoms of genital atrophy and sexual responsiveness
- Reduces the effects of age related/hormone mediated psychogenic symptoms Improves libido and sex drive
- Improves physical stamina, endurance and results of exercise
- Improves muscle bulk and tone
- Improves lipid metabolism
- Improves Glucose/sugar metabolism and reduces the risk of type 2 diabetes
- Provides a more beneficial hormonal environment for weight management

- TESTOSTERONE WARNING: SECONDARY EXPOSURE TO TESTOSTERONE
  - Virilization has been reported in children who were secondarily exposed to testosterone.
  - Children should avoid contact with unwashed or unclothed application sites in individuals using testosterone gel.
- I understand that the typical side effects associated with the use of testosterone may include but are not limited to oily skin, acne, moodiness, irritability, change in libido (most often an increase), hirsutism (facial hair growth) and scalp hair loss, hair growth where topical testosterone is applied, enlargement of the clitoris, voice changes (usually deepening), water retention, slight bruising or infection at the injection/pellet insertion site(if injection or pellet therapy is used), increased hematocrit in the blood count, alteration of lipid profile, changes in blood pressure, and insulin sensitivity changes.
- I understand that smoking may substantially increase all risks associated with hormone replacement therapy and that it is an established medical fact that stopping smoking is an overall benefit to health and wellness.
- I agree to contact my provider and if necessary, seek immediate medical attention, in the event I knowingly develop any adverse side effects of any hormone therapy.

I understand that the use of estrogen is still controversial in the traditional medical community. A lot of the negative feeling against estrogen replacement therapy arose from the Women's Health Initiative Study that was published by the National Institute of Health in 2002. The study did not evaluate bio-identical hormones, however it did evaluate the effects of Premarin (a horse urine derivative) and Provera (a chemicalized, synthetic progestin). Among other things, the study found the following:

- 41% more strokes (29 HRT VS 30 placebo in 10,000 person years)
- 29% more heart attacks (37 HRT VS 30 placebo in 10,000 person years)
- Twice as many blood clots (34 VS 16 placebo in 10,000 person years)
- 26% more breast cancer (38 VS 30 placebo in 10,000 person years)
- 66% increase in Alzheimer's Dementia (45 HRT VS 22 in 10,000 person years)
- 37% less colorectal cancer (0.63 relative risk reduction)
- 33% fewer hip fractures (0.66 relative risk reduction)

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However, in multiple studies (one with over 80,000 women) completed since the WHI, the use of bio-identical hormones has shown no increase in cancer risk. In fact, some suggest a reduction in cancer risk when bioidentical estrogen and progesterone are properly balanced with each other and managed by a properly skilled physician. The bottom line is that bio-identical hormone replacement is intuitively safe in that it only replaces natural hormones to a physiological level that once was normal in the human body.

- Overall, it is the opinion of the health care provider that the risks of prolonged hormone imbalance in the aging years is far greater than any risk shown to be associated with the use of bio-identical hormone therapy. That is, the risk of illness and dying early is greater if treatment is withheld as opposed to initiating and continuing bioidentical hormone therapy through the aging years.
- I understand that when hormones are applied topically as a cream or a gel, they may transfer to others resulting in hormonal excess in those to whom the transference has occurred
- I understand the importance of maintaining a healthy lifestyle with the use of hormone replacement, and agree to continue with a recommended program of healthful nutrition, regular exercise, stress management and nutritional supplementation with the use of testosterone. I further agree to continue any other hormone replacement therapies recommended by my physician.
- The safe use of bio-identical hormone replacement therapy requires proper medical monitoring. To that end I understand that I will be required to undergo routine testing and medical screening as current medical standards indicate for the following:
    - Assessment for physical side effects 4-8 weeks after initial replacement and regularly thereafter.
    - Salivary or Blood hormone testing.
    - Other hormone levels may be monitored, as well as other blood tests ordered as appropriate for treatment.
    - Routine Blood work as necessary.
    - PAP smears.
    - Mammograms.
    - DEXA – bone density scans.
    - Trans-vaginal Ultrasound evaluation as indicated.
    - Annually physical exam by your primary doctor and/or your OB/GYN

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Statement of Patient:

I understand that along with the benefits of any medical treatment or therapies, there are both potential risks and complications to treatment. Those risks and complications have been explained to me and I agree that I have received information regarding those risks, complications and benefits, and the nature of bio-identical and other hormone treatments and have had all my questions answered. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. By signing below, I agree and give my consent to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Wellness and Age Management physician, my primary care physician, or other specialist. I agree to see my primary care physician, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, GYN examinations, colonoscopy, EKG, etc. (as indicated). at least on a yearly basis.

I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I agree to testosterone therapy as described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient: _____ Date: _____

Name (Print): _____

Statement of clinical educator: I have explained the therapy described above, its intended benefits and risks, and possible reactions to the patient. I have confirmed that the patient has no further questions and wishes to initiate bioidentical hormone replacement therapy and the patient has verbalized to me his/her understanding of those risks and benefits he is giving verbal and written consent to initiate this therapy.

Name of Physician Explaining Procedures: _____ Date: _____

Signature of Physician: _____

This consent is ongoing for this and all future BHRT Treatments.

Initials MD: _____ / Pt: _____

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Medicare Private Contract for Services from Physician who has Opted Out

This Private Contract is entered into by and between:
Patient Name or Legal Representative: _____
(each one referred to herein as "Patient") and **John Christy Carrozzella, MD** ("Doctor") pursuant to the Medicare requirements that relate to physicians who have opted out of Medicare. Doctor has filed the required Affidavit with Medicare within the time period required for this Private Contract to be effective.

1. Doctor's Obligations. Doctor hereby informs Patient of the following and agrees to undertake the following actions:
    a. Doctor has not been excluded from participation in Medicare under §§1128, 1156 or 1892 of the Social Security Act. The decision to opt out of Medicare was a strictly voluntary one.
    b. Doctor will make a copy of this Private Contract available to CMS upon its request.
    c. The expected or actual effective date and the expiration date of the opt-out period to which this Private Contract applies are as follows: April 1, 2016 and March 31, 2018.
    d. Doctor and Patient must enter into a new Private Contract for each opt-out period.
    e. Doctor will provide a photocopy of this Private Contract to Patient or to Patient's legal representative before items or services are furnished to Patient under the terms of this Private contract.
    f. Doctor will retain an original of this Private Contract with original signatures of both parties, for the duration of the opt-out period, although a scanned copy shall carry the same weight as the original.

2. Patient's Obligations. The Patient or the Patient's legal representative agrees to the following:
    a. Patient accepts full responsibility for payment of Doctor's charge for all services furnished by Doctor.
    b. Patient understands that Medicare limits do not apply to what Doctor may charge for items or services furnished to Patient by Doctor.
    c. **Patient agrees not to submit a claim to Medicare or to ask Doctor to submit a claim to Medicare.**
    d. Patient understands that Medicare payment will not be made for any items or services furnished by Doctor that would have otherwise been covered by Medicare if there was no Private Contract and a proper Medicare claim had been submitted.
    e. Patient has entered into this Private Contract with the knowledge that Patient has the right to obtain Medicare-covered items and services from a physician who has not opted out of Medicare, and that Patient is not compelled to enter into Private Contracts that apply to other Medicare-covered services furnished by other physicians who have not opted out.
    f. Patient understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

g. Patient entered into this Private Contract at a time when Patient did not require any emergency or urgent care services.

3. Controlling Law. The terms of this Private Contract shall be interpreted and controlled by applicable Medicare regulations, as amended from time to time. Both parties agree to comply with all such Medicare regulations and enter into such agreements as may be required from time to time by such regulations.

4. Patient Representative. If this Private Contract is being signed by a Patient Representative on Patient's behalf, the Patient Representative will provide Doctor with the documentation required to demonstrate that Patient Representative has the requisite legal authority to sign this Private Contract on Patient's behalf.

The parties have read and understood the provisions of this Private Contract and enter into this agreement freely and voluntarily.

Doctor:

_____
John Christy Carrozzella, MD

Date:

Patient/Patient Representative:

_____
Name:

Relationship to Patient:

Date:

An electronic copy of this document shall carry the same weight as an original.

Florida Center for Hormones and Wellness

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Full Name: _____ Date of Birth: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR§164.508]

I authorize Dr. John Carrozzella, my physician and/or administrative and clinical staff to (check all that apply):

☐Obtain & use the following protected health information from: ☐ Disclose the following protected health information to:

Name of entity or persons: _____ Phone: _____

Address: _____ Fax: _____

PLEASE SEND RECORDS VIA: ☐Fax ☐Mail ☐Other: _____

Description of information requested for use or disclosure:

☐Routine Visit Notes/Summary ☐Initial Evaluation Records ☐ Complete Chart ☐ Discharge Summary ☐Billing Records

☐ Emergency Department Records ☐Radiology Reports ☐ Lab Reports ☐Operative Reports ☐Pathology Report

☐Other: _____

Purpose for use or disclosure of this protected health information: ☐ Treatment ☐At the request of the individual (patient)

☐Insurance ☐Legal Action ☐Other: _____

I understand that this authorization shall be in force and effect until the following expiration date, event or condition: _____, and that failure to specify will result in the authorization expiring in one year.

1. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at the above practice address.
2. I understand that a revocation is not effective to the extent that the above-named has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
3. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
4. I understand that the protected health information requested above may include information, diagnostic tests, treatment records, and notes related to psychiatric evaluations and substance abuse, and I fully consent to the release of the protected health information outlined above unless initialed and restricted per the following:

_____ *(Initial) The protected health information requested above may NOT include information related to:*

_____

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign this Authorization.

If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. _____ [*Patient Initials if applicable*]

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

……

*****Revocation*****

(To be completed by patient if patient subsequently wishes to revoke authorization)

I hereby revoke this Authorization. Patient Signature: _____ Date: _____

[Provide a copy of this form to the patient.]

An electronic copy of this document shall carry the same weight as an original.

Florida Center for Hormones and Wellness
7575 Dr Phillips Blvd – Suite 370
Orlando, FL 32819
Ph: 407-507-3837
Fax: 407-507-3841

Notice of Privacy Practices

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. THE PRIVACE OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information ('PHI'). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 15, 2013, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law.

We reserve the right make the changes in our privacy practices and the new terms of our effective Notice for all PHI that we maintain, including medical information we created or received before we made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We may use and disclose your PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosers of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party or to other physicians who may be treating you. For example, we would disclose your PHI to other physicians in order to diagnose or treat you. In addition, we may disclose your PHI from time to time to another physician or health care provider (e.g. specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use disclose, as needed, your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your PHI, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associates involves the use or disclose of your PHI, we will have a written contact that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your PHI will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Other Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Marketing: We may use your PHI to contact you with information about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the

health or safety of others. We may disclose your PHI to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public heath purposes.

Health Oversight: We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or of others. We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable state and federal laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Heath and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your PHI to law enforcement officials.

We may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You must make a request in writing to the primary practice location where you have most recently received service. You may also request access by sending us a letter to the address at the end of this notice.

Accounting for Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contacts us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make on such a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continue to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain the notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Contact Persons: Amanda Grijalva
Florida Center for Hormones and Wellness
7575 Dr. Phillips Blvd – Suite 370; Orlando, FL 32819
(407) 507-3837

An electronic copy of this document shall carry the same weight as an original

Florida Center for Hormones and Wellness

7575 Dr. Phillips Blvd – Suite 370
Orlando, FL 32819
(407) 507-3837Fax: 888-552-7536

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Florida Center for Hormones and Wellness's Notice of Privacy Practices.

An electronic copy of this document shall carry the same weight as an original

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Personal Representative's Relationship to Patient: _____

Date: _____

Florida Center for Hormones and Wellness

7575 Dr. Phillips Blvd – Suite 370
Orlando, FL 32819
(407) 507-3837

The Florida Center for Hormones and Wellness offers our patients communication by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.
- E-mail may not conform to the requirements of Health Insurance Portability Act of 1996 ("**HIPAA**").
- E-mail does not allow us to guarantee that you have received or understand our response.

HOW WE WILL USE E-MAIL: We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients. We will use e-mail to communicate with you only about non-sensitive and non-urgent issues. All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file. Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling. We will not disclose your e-mails to others unless allowed by state or federal law or with your written consent. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL…CALL 911. Also, do not use e-mail for **urgent problems**. If you have an urgent problem, call our office (407) 507-3837 or go to an urgent care facility. . **Emails should not be time-sensitive.** While we try to respond to email messages daily, it may take up to three (3) working days or more for us to respond to your message. Urgent messages or needs should be relayed to us by using regular telephone communication. If you have not heard back from us within three days, call our office to follow up if we have received your email.

GUIDELINES FOR E-MAIL COMMUNICATION

1) Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."
2) Include your name and phone number in the body of the message.
3) Review your message to make sure it is clear and that all relevant information is included before sending.
4) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
5) If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
6) Take precautions to protect the confidentiality of e-mail, such as safeguarding your computer password and using screen savers.
7) Inform us of changes in your email address.

Patient Initials _____

Florida Center for Hormones and Wellness

7575 Dr. Phillips Blvd – Suite 370
Orlando, FL 32819
(407) 507-3837

CONSENT TO USE EMAIL COMMUNICATION

I, _____,
(print name)
am:

_____ a) an established patient of Dr. John Carrozzella.

_____ b) the legal representative of an established patient,

I may want to communicate with Dr. John C Carrozzella and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that Email communication may not conform to the requirements of Health Insurance Portability Act of 1996 ("**HIPAA**") I understand that Dr. John C Carrozzella cannot guarantee the security and confidentiality of e-mail communication. Dr. John C Carrozzella will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with Dr. John C Carrozzella by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Email will not be used to discuss any new issues or any sensitive medical information. Appointments should be made to discuss these issues.

I understand that Dr. John C Carrozzella and/or his representative may use email to communicate with me for the purposes of providing educational material or regarding any products or services that Dr. Carrozzella feels are relevant to good patient care.

I understand that either I or Dr. John C Carrozzella may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising Dr. John C Carrozzella in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Dr. John C Carrozzella.

An electronic copy of this document shall carry the same weight as an original.

_____ _____
(signature) (date)

_____ I decline / withdraw consent to use email as a communication tool

_____ _____
(signature) (date)