METABOLIC
CENTER *for* WELLNESS

PERSONAL INFORMATION

First Name_____ Middle _____ Last _____

DOB _____ SS#___-__-____ Sex ☐M ☐F Marital Status _____

Street Address_____

City _____ State _____ ZIP code _____

Home Phone #_____ Work Phone # _____

Cell Phone # _____ E-mail _____

HIPAA COMPLIANCE

Which phone #s may we call to discuss your care? ☐ Home ☐ Cell ☐ Work

On which phone may we leave a voice mail message? ☐ Home ☐ Cell ☐ Work ☐ None

PRIMARY CARE PHYSICIAN

Name_____

Phone # _____ Fax # _____

Address _____

PLEASE LET US KNOW WHO REFERRED YOU (IF APPLICABLE)

Name_____

PATIENT'S EMPLOYMENT INFORMATION

Employer _____

Occupation _____ Phone # _____

Street Address_____

City _____ State _____ ZIP code _____

SPOUSE INFORMATION

Name_____ DOB _____

Cell phone # _____ Work phone # _____

May we discuss your medical care with your spouse? ☐ Y ☐ N

Can we discuss your medical care with anyone other than your spouse? ☐ Y ☐ N

Name_____

Relationship _____ Phone # _____

EMERGENCY CONTACT

Name_____

Relationship _____ Phone # _____

HEALTH INSURANCE INFORMATION

Primary Insurance Company_____ ID# _____

Policy Group #_____ Group Name _____

Subscriber's name_____ DOB _____

Secondary Insurance Company _____ ID# _____

Policy Group #_____ Group Name _____

Subscriber's Name _____ DOB _____

PHARMACY INFORMATION

Local Pharmacy Name _____ Phone/Fax # _____

Mail Order Pharmacy _____ Phone/Fax # _____

OTHER SPECIALISTS YOU CURRENTLY SEE

Specialist	**Name**	**Phone #**
Cardiology	_____	_____
Neurology	_____	_____
Nephrology	_____	_____
OB/GYN	_____	_____
Opthalmology	_____	_____
Podiatry	_____	_____
Psychiatry	_____	_____

Signature _____ Date _____
(Patient and/or responsible party)

METABOLIC
CENTER *for* WELLNESS

WELCOME TO METABOLIC CENTER *for* WELLNESS

Thank you for your trust in our care. We strive to work with you to reach and maintain your personal health goals.

Our mission is to improve lives and wellness through the achievement of individualized integrative endocrine and metabolic balance.

To accomplish the maximum benefit of your **first visit**, in addition to arriving **30 minutes** prior to your scheduled appointment, we ask that you bring the following:

- Your completed new patient paperwork
- Your photo ID
- Your insurance card and referral, if required. If you need a referral, it is *your* responsibility to ensure that it is available at the time of your visit. If it is not, you may be rescheduled.
- A list of medications (including insulin and over-the-counter meds or supplements) that you take.
- Any medical records that relate to the reason why you are visiting us.

Office policies

- We ask that you arrive **at least 10 minutes ahead of time for all follow-up visits**.
- Our practice is limited to endocrinology. The remainder of your health needs should continue to be followed by your primary care doctor. If you do not have a primary care doctor, we can give you recommendations.
- Our practice is also limited to in-office patient care. We do not admit nor follow patients who are admitted to the hospital.
- Prescription refills
  - Prescriptions not written by Dr. Angela Mazza need to be filled by the prescribing doctor.
  - Please allow *3 business days for refill requests*.
  - It is your responsibility to know what refills you need at the time of your visit.
- Lab results
  - All lab results, unless critical, will be discussed at the time of your appointment.
  - Most lab requests are sent electronically, but it is your responsibility to keep the lab confirmation given to you at your visit.
- If you miss your appointment 3 times and/or excessively rebook appointments, you will be discharged from the clinic.
- Any and all questions will be answered at the time of your visit. Be proactive and be prepared with your questions concerning your healthcare before your visit. ***Phone calls should be reserved for emergency issues only.*** Please allow 48 hours for the return of any non-urgent messages.

Financial policies

- Any co-pay or deductible is expected to be paid in full upon check-in. Please be prepared to pay at the time of your visit. Please contact your insurance company before your visit if you are unsure about your responsibilities, co-pays or deductibles.
- There is a $195 yearly fee at our clinic.
- Our patients receive 10% off retail price on all pharmaceutical-grade supplements and nutraceuticals.
- No-Shows
  - **All cancellations require at least 48 hours advance notice.** Otherwise, for an initial consultation no-show, there will be a $200 charge and for a follow-up appointment no-show, there will be a $50 charge
- If your balance is not paid in full within 60 days of the dated bill, an additional $50 will be added to your balance.
- Any balance not paid in full by 90 days will carry an additional $10 charge for administrative fees, and all collection fees will be the responsibility of the patient. Delinquent overdue balances will result in discharge from the clinic.

We look forward to working together for your wellness!

Sincerely,

Metabolic Center for Wellness

I have read and understood the above information.

Name (printed) _____

Patient or Guardian Signature _____ Date _____

METABOLIC
CENTER *for* WELLNESS

Name_____ DOB _____

PERSONAL HISTORY

MEDICAL PROBLEMS Do you have or have you ever been diagnosed with the following?

- ☐ Adrenal gland disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Gall bladder disease
- ☐ Gout
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Hives or eczema
- ☐ Kidney disease
- ☐ Migraine headaches
- ☐ Osteoporosis
- ☐ Pituitary disease
- ☐ Psychiatric disorder
- ☐ Reflux
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease

Other_____

CURRENT SYMPTOMS Are you currently experiencing any of the following?

- ☐ Abdominal pain
- ☐ Anxiety or depression
- ☐ Bleeding or lymph node issue
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Change in voice
- ☐ Chest pain
- ☐ Constipation
- ☐ Cough or wheeze
- ☐ Dental or gum problems
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Fevers or night sweats
- ☐ Headaches
- ☐ Increased thirst
- ☐ Joint pains
- ☐ Muscle pains
- ☐ Nausea or vomiting
- ☐ Numbness or tingling
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Sinus issues
- ☐ Skin rashes or hives
- ☐ Trouble or pain swallowing
- ☐ Urination: more frequent
- ☐ Urination: painful
- ☐ Vision: blurred
- ☐ Vision: decreased
- ☐ Weight gain
- ☐ Weight loss

WOMEN

Menstrual cycle (periods)

Age at first period _____

Date of last period _____

Regular? ☐ Y ☐ N

Heavy or painful? ☐ Y ☐ N

Decreased libido ☐ Y ☐ N

Sexual dysfunction ☐ Y ☐ N

Breast discharge ☐ Y ☐ N

MEN

Decreased libido ☐ Y ☐ N

Erectile dysfunction ☐ Y ☐ N

Prostate disease ☐ Y ☐ N

Other

Name_____ DOB _____

SURGICAL HISTORY Please list any surgeries you have had

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

ALLERGIES Please list

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Are you employed? ☐ Y ☐ N
If YES, what is your occupation? _____

Do you smoke tobacco? ☐ Y ☐ N
If YES, how much and how often? _____

Do you drink alcohol? ☐ Y ☐ N
If YES, how much and how often? _____

FAMILY HISTORY List any family members who have the following conditions.

☐ Y ☐ N Cancer _____

☐ Y ☐ N Diabetes _____

☐ Y ☐ N Heart disease _____

☐ Y ☐ N High blood pressure _____

☐ Y ☐ N High cholesterol _____

☐ Y ☐ N Kidney disease _____

☐ Y ☐ N Thyroid disease _____

Other_____

Name_____ DOB _____

MEDICATION Please list all medications you take and their doses. Please include any insulin or over-the-counter supplements.

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

WHAT IS THE MAIN REASON OR CONCERN FOR YOUR VISIT TODAY?

METABOLIC
CENTER *for* WELLNESS

Name_____ DOB _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned person hereby consents to the evaluation or treatment that the assigned healthcare provider may deem necessary to the patient named above.

_____ _____

PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Metabolic Center for Wellness, P.A., I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

PATIENT SIGNATURE DATE

FOR MEDICARE PATIENTS ONLY

LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

_____ _____

PATIENT NAME (PRINTED) DATE

_____ _____

PATIENT SIGNATURE DATE

_____ _____

MEDICARE B# DATE

METABOLIC
CENTER *for* WELLNESS

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED, DISCLOSED AND ACCESSED.

1. Introduction

Metabolic Center for Wellness, P.A., is required by law to provide notice of its legal duties and privacy practices, as well as maintain the privacy and security of your health information. Metabolic Center for Wellness, P.A., is required to abide by the terms of the Notice currently in effect, but reserves the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information (PHI) under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) and further expanded by the Health Information Technology for Economic Clinical Health Act (HITECH).

PHI includes demographic information that can be used to identify you, such as your name, address, and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, or future payment for healthcare. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Metabolic Center for Wellness, P.A.

If you have any questions about the Metabolic Center for Wellness, P.A., Notice of Privacy Practices, please contact Jeffrey C. Misiewicz at (407)542-0661.

2. Safeguarding Your PHI

We have appropriate administrative, technical, and physical safeguards in place to protect and secure the privacy of your PHI. Medical records are maintained in secure areas within our practice and electronic medical records systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. We train our employees on the regulations and policies that are in place to protect the privacy and security of your medical records and PHI and only employees who have a legitimate “need to know” are permitted access. Our employees understand their legal and ethical obligations to protect your PHI and that a violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of our registration material, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by Metabolic Center for Wellness, P.A., and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with laboratory or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.

- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, processing claims, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.

- **Health Care Operations.** Health care operations means the legitimate business activities of our practice. These activities may include quality assessment and improvement; fraud and abuse compliance; business planning and development; and business management and general administrative functions. These can also include appointment reminders by phone, or translation services to communicate with you in person or by phone, in a language other than English.

Any third parties involved in our business activities sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may electronically transfer your PHI to other treating health care providers. We may also electronically transmit your information to your insurance carrier.

5. Uses and Disclosure of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for psychotherapy or marketing purposes, and those that constitute a sale, will be made only with your written authorization.

Other uses and disclosures of PHI will be made only with your specific written authorization. This allows you to request that Metabolic Center for Wellness, P.A., disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to parties not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. In these situations, we will ask you to sign an authorization allowing us to disclose PHI to the designated parties.

If Metabolic Center for Wellness, P.A., intends to engage in fundraising or research, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back disclosures already made with your permission.

6. Uses and Disclosures of PHI Permitted or Required by Law.

In some circumstances, we may be legally permitted or required to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.

- **Others Involved in Your Healthcare.** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate, only the PHI that directly relates to that individual's involvement in your health care and treatment. We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.

- **Communication Barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers, and your physician, using his or her professional judgment, infers that you consent to such use or disclosure, or determines that a limited disclosure is in your best interests, we may permit such use or disclosure.

- **Required by Law.** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

- **Public Health/Regulatory Activities.** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to appropriate regulatory agencies.

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

- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.

- **Judicial and Administrative Proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligations compelling us to do so, or with your permission.

- **Law Enforcement Activities.** We may disclose your PHI to a law enforcement official to identify or locate a suspect, fugitive, or missing person, or to comply with a court order or for other law enforcement purposes. Under some limited circumstances we will request your authorization prior to permitting disclosure.

- **Coroners and Medical Examiners.** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful purpose.

- **Funeral Directors and Organ Donation Organizations.** We may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.

- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure its privacy and security.

- **Serious Threats to Health or Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- **Military and National Security Activities.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military authorities to assure proper execution of military missions. We also may disclose your PHI to certain federal officials for lawful intelligence and other national security activities.

- **Workers' Compensation.** We may disclose your PHI as authorized to comply with workers' compensation laws.

- **Inmates of a Correctional Facility.** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received PHI in the course of providing care to you while in custody.

- **U.S. Department of Health and Human Services.** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with privacy and security laws.

- **Disaster Relief Activities.** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross) if authorized to assist in disaster relief efforts.

7. Your Rights Regarding PHI

- **Right to Request Restrictions for Certain of Uses and Disclosures.** You have the right to request that we not use or disclose your PHI unless such use or disclosure is required by law. Such a request must be made in writing and include the specific PHI you wish restricted, as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we are not required to disclose your requested restriction except in the case of restricting disclosure of PHI to a health plan as described below.

If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service paid for out-of-pocket and in full, we will abide by your request. Such a request must be made in writing to the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.

- **Right to Access.** You have the right to inspect and obtain a copy of your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond as soon as possible, but no later than 30 days from the date of your request. In very limited circumstances, we may deny access to your PHI. If access is denied you will receive a denial letter within 30

days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party, provided such request is made in writing, signed by you and clearly identifies the designated third party and location to send your PHI.

- **Right to Confidential Communications.** You have the right to request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Such requests must be made in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request, and will accommodate reasonable requests.

- **Right to Amend.** You have the right to request, in writing, that we amend your PHI. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial. Metabolic Center for Wellness, P.A., has the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.

- **Right to an Accounting of Disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment, or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide, free of charge, one accounting every 12 months. For any subsequent accounting requests, we will charge a reasonable fee based upon our costs.

- **Right to a Copy of our Notice of Privacy Practices.** We will ask you to sign a written acknowledgment of receipt for our Notice of Privacy Practices. We may update this Notice of Privacy Practices at any time. Upon your request, we will provide you with a current copy of this Notice.

- **Right to Notice of Breach.** You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- **Within our Practice.** If you have a complaint about the denial of any of the specific rights listed above, our Notice of Privacy Practices, or our compliance with state and federal privacy laws, you may receive more information about the complaint process by contacting the practice Privacy Officer at (407)542-0661.

- **Outside our Practice.** If you believe that Metabolic Center for Wellness, P.A., is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.

- We will not retaliate against you for filing a complaint.

9. Effective Date. This notice is effective as of July 1, 2015.

METABOLIC
CENTER *for* WELLNESS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand the Metabolic Center for Wellness, P.A., **Notice of Privacy Practices** containing a description of the uses and disclosures of my health information. I further understand that Metabolic Center for Wellness, P.A., may update its **Notice of Privacy Practices** at any time and that I may receive an updated copy by submitting a request in writing.

Patient

Name (printed) _____

Signature _____ Date _____

Patient's personal representative (if applicable)

Name (printed) _____ Relationship _____

Signature _____ Date _____

FOR OFFICE USE ONLY

Complete this form if unable to obtain signature of patient or patient's personal representative.

Metabolic Center for Wellness, P.A., made a good-faith effort to obtain the patient's written acknowledgment of the **Notice of Privacy Practices**, but was unable to do so because the patient or patient's personal representative—

☐ Refused to sign

☐ Was unable to sign

☐ Other

Employee

Name (printed) _____

Signature _____ Date _____