VENATION CTR

06

FL 33410

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06

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PHYSICIAN

PATIENT LAST NAME

SEX ○M ○F

DATE COLLECTED

TIME COLLECTED ○AM ○PM

REQUIRED: ICD9 Diagnosis Codes

RELATIONSHIP TO INSURED

INSURANCE PAYER ADDRESS

SOCIAL SECURITY NUMBER

Tests which may require an Advance Beneficiary Notice appear in Blue (See Back)

WRITE-IN TESTS

CUSTOM TESTS

■ IGF-1 Testing

■ PSA Testing - Males Only

[ ]

[ ]

[ ]

[ ]

COMMENTS

LENEXA, KS 66215

1 - 800 - 646 - 7788

Total Health & Rejuvenation **Basic Exam**

Was picture ID shown for verification? Yes ☐ NO ☐

____
Company

Name of Patient______________________ D.O.B.____________ Sex: ☐ Male ☐ Female

Address____
Street City/Town State Zip Code

Family Physician______________________ Date & Reason Consulted______________

Address____
Street City/Town State Zip Code

Treatment and/or Medication Prescribed? ☐ Yes ☐ No (If Yes, give details in #8 Remarks Section)

	YES	NO
1. Have you ever consulted any medical practitioner for, or so far as you know, ever been treated for:		
A. Any disorder of eyes, ears, nose or throat, including speech impairment or loss of sight?	☐	☐
B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hayfever, spitting blood, or persistent hoarseness or coughing?	☐	☐
C. Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins?	☐	☐
D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis?	☐	☐
E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic?	☐	☐
F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches?	☐	☐
G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization?	☐	☐
H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg or hip, or back disorder?	☐	☐
I. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema?	☐	☐
2. Have you ever:		
A. Had a surgical operation?	☐	☐
B. Been told to have an operation that wasn't performed?	☐	☐
C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram?	☐	☐
D. Lived with someone who has had T.B. in the last 2 years?	☐	☐
E. Had a weight change in the past year? If yes, reason? (List below)	☐	☐
F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed forces?	☐	☐
G. Ever applied for or received any pension or benefits for sickness, disability or accident?	☐	☐

	YES	NO
3. Other than previously stated, as far as you know, have you in the last 5 years:		
A. Had any illness, disease or injury?	☐	☐
B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc.	☐	☐
C. Consulted any medical practitioner for any reason (including check-ups?)	☐	☐
D. Any reason to feel you are not in good health?	☐	☐
E. Are you taking any medication or drugs?	☐	☐
4. For women only:		
A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below)	☐	☐
B. Any disorder of the breasts or female organs?	☐	☐

5. A. Family History

Family Record	Age If Living	Condition of Health If not "Good," give details	Age At Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

	YES	NO
B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide?	☐	☐
6. Do you participate in regular exercise? If yes, describe type and frequency. (list below)	☐	☐
7. Smoking Habits:		
Do you smoke cigarettes? If yes, packs per day (list below)	☐	☐
If non-smoker, did you ever smoke cigarettes? If yes, for how long, packs per day and when did you quit? (list below)	☐	☐

Initials_________

8. Remarks: Please give full details for any questions above answered "Yes".

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

9. Male/Date of last prostate exam_________________________ Physician Name_________________________________

10. Female/ Date of last pap smear_________________________ Date of last mammogram__________________________
    Physician Name_____________________________________

11. Pulse______________per/minute ☐ Regular ☐ Irregular
    Number of Irregularities, if any ____________

12. Blood Pressure

	1st Reading	2nd Reading	3rd Reading
Systolic	_______	_______	_______
Diastolic	_______	_______	_______

To be taken at separate intervals and if systolic is 140 or over, or diastolic is 90 or over, repeat after 10 minutes rest. Then take 2 additional readings.

13. Height ____________(without shoes)
    Weight ___________

14. Urinalysis (Dipstick)
    Glucose_________________
    Albumin_________________

13. Measurements (Males Only)
    Chest at full inspiration_________
    Chest at forced expiration_____________
    Abdomen at umbilicus ________

14. Did you weigh? ☐ Yes ☐ No
    Did you measure? ☐ Yes ☐ No

15. Chief complaint (as stated by patient):

16. Remarks:

Initals___________

Patient Authorization and Agreement

HDEXBEe 8/02

In consideration of instructs Total Health & Rejuvenation Center ("THARC") providing the submitting patient ("Patient") with medical management, administrative and referral services, Patient acknowledges and agrees to the following terms and conditions contained in this Patient Authorization Agreement ("Agreement"). With this agreement, Patient submits with this Agreement an accurately completed Medical History Form ("MHF"). Patient agrees to respond to truthfully, accurately and completely in completing the MHF and acknowledges that failure to provide truthful, accurate and complete information on the MHF or to THARC or the physicians referred by THARC could result in inappropriate treatment. Patient authorizes and THARC to obtain on my behalf medical laboratories, diagnostic testing, physicians and dispensing pharmacies. In addition, Patient authorizes and instructs THARC and physicians referred by THARC ("Physicians") and dispensing pharmacies obtained on my behalf to provide medical care and prescribed pharmaceuticals based on the MHF, laboratory diagnostic tests, and other information submitted to THARC under this Agreement. Patient agrees to present photo identification upon any blood testing pursuant to a THARC or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by THARC, and medical services provided to me by Physicians, are not covered or reimbursed by Medicare or other insurance.

Patient acknowledges that THARC's employees and advisors are no licensed physicians and that Physicians obtained on my behalf by THARC are independent contractors, which will be compensated by Patient with funds provided to THARC. I further understand and agree that THARC and Physicians are rendering the medical care, services and treatment and that THARC is instructed and authorized to arrange for the prescribed pharmaceuticals to be dispensed and sent to me by any pharmacy in my country of residence.

Patient covenants and agrees to comply with the method of instructions, treatment and dosage schedules prescribed by Physician, to immediately cease any medical treatment prescribed by Physician in the event of any adverse reaction or side effect arising from prescribed treatment and to immediately provide THARC and Physician with written notice of any such adverse reaction or side effect. I further acknowledge and agree that THARC is not liable for any negligent act or omission of the Physician.

Patient acknowledges that diagnosis and treatment may involve risk of injury, and that THARC and Physician have made no guarantees or warranties with respect to the above-described diagnostic testing, analysis of test results, examination of medical history or hormone treatment. Patient acknowledges that the hormone blood level objective sought as a result of Patient's hormone replacement therapy, as prescribed by Physician, may be the highest level of standard reference range for Patient's age and sex, or, in some cases, above such range, to the level of a younger person, and that such range is experimental and may not render any benefits, but may result in unknown, adverse results.

Patient is aware of the nature, risk and possible alternative methods of treatment, possible consequences, and possible complications involved in such hormone replacement treatment. Patient acknowledges that recombinant human growth hormone replacement therapy involves the use of a medical drug approved for one purpose for a new and different purpose in an effort to obtain a desired objective of medical treatment. Nonetheless, Patient consents to such care and treatment, and executes this Agreement with a complete, informed understanding of such hormone replacement therapy for the purpose of authorizing Physician to administer such treatment to relieve body ailments and attempt to enhance Patient's physical condition and health. Patient further acknowledges that the methods of medical treatment offered by THARC and Physician are not accompanied by claims, guarantees, promises or warranties.

Patient is freely seeking medical consultation via the internet and acknowledges and consents to Physician reviewing Patient's medical history without the opportunity to conduct an in-person physical examination. Patient solicits THARC for a specific prescription medication to treat an already-identified medical or cosmetic condition. Patient acknowledges that Physician may not be licensed to practice medicine in Patient's state or country of residence. Further, Patient agrees that Physician's consultations, diagnosis, and treatments will be deemed to have occurred in Florida, where Physician is licensed to practice medicine.
Patient represents that he or she is under the care of a primary care physician and the Physician will not rely or substitute the advice of Physician should it conflict with the advice given to me by Patient's primary care physician. Before taking any medication prescribed by Physician, Patient agrees to have a comprehensive physical examination by his or her primary care physician. Patient agrees to notify his or her primary care physician and advise such physician that Patient is undergoing hormone replacement therapy.

This Agreement shall be governed, construed and enforced in accordance wit the laws of the State of Florida, applicable to agreements made and to be performed entirely within such State, without regard to principles of conflict of laws. Any disputes arising out of , in connection with or with respect to this Agreement, shall be adjudicated in a court of competent jurisdiction sitting in the Palm Beach County, Florida and nowhere else. Patient hereby irrevocably submits to the jurisdiction of such court for the purposes of any suit, civil action or other proceeding arising out of, in connection with or with respect to this Agreement. In the event of any litigation arising out of this Agreement, the prevailing party shall be entitled to recover all expenses and costs incurred, including reasonable attorneys' fees and legal assistants' fees.

This Agreement contains the entire understanding of the parties and supersedes and merges all prior and contemporaneous agreements and discussions between the parties. Any and all representations or agreements by any agent or representative of either party not contained in this Agreement shall be null, void and of no effect. If any provision of the Agreement or the application thereof to any person or circumstances is held invalid or unenforceable in any jurisdiction, the remainder hereof, and the application of such provision to such person or circumstances in any other jurisdiction, shall not be affected thereby, and to this end the provisions of this Agreement shall be server able.

Patient covenants and agrees to indemnity, defend, protect and hold harmless THARC and Physician and their respective officers, directors, employees, stockholders, assigns, successors and affiliates ("Indemnified Parties") from, against and in respect of all liabilities, losses, claims, damages, punitive damages, causes of action, lawsuits, administrative proceedings, investigations, demand, judgments, settlement payments, deficiencies, penalties, fines, interest and costs and expenses suffered, sustained, incurred or paid by the Indemnified Parties in connection with, resulting from or arising out of, directly or indirectly, THARC and/or Physician's rendering medical care, services, advice and/or treatment.

Patient's failure to disclose all relevant information regarding Patient's medical and physical condition, acts or omissions of THARC or Physician, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by THARC or Physician. Patient is aware of potential side effects associated with the above-described treatment, accepts all risks involved in taking medication and will not seek indemnification or damages from the Indemnifications Parties there from.

Initials___________

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I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the Total Health Examiner is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly.

Dated at_________________________ on_________________________ 19__________

Witnessed by_________________________
Portamedic Examiner

Signature of Person Examined_________________________

Total Health & Rejuvenation Center Address:

Total Health & Rejuvenation Center
Gardens Medical Park
3345 Burns Road, Suite 206
Palm Beach Gardens, Florida 33410

Health Survey Information Authorization
I hereby authorize the release of this medical information to Total Health & Rejuvenation Center and Their attending Physicians.

____
Signature of Patient Date

____
Signature of Witness/Examiner Date

____
Please Print Name of Patient

____
Please Print Name of Witness/Examiner