ASPIRE
REJUVENATION

Please complete the forms as thoroughly and honestly as possible. You do not need to complete the credit card portion if you do not want to, it is simply for easier reordering through the system.

Please attach:

1. Photo or copy of you drivers license
2. Front and rear of your insurance card, if using insurance for blood-work.

If you have recent blood-work please attach a copy to the email. If you need blood-work done via cash pay, the fee is $150.00 for a full panel. When using insurance please call and ensure your insurance will cover the cost of lab-work to avoid any charges. We are considered a specialty clinic and out of network for insurance. We are not responsible for any fees not covered by your insurance.

There is no fee for your initial consultation for new patients who get treatments through us. If you only want a lab reading and consultation, there is a $100 fee associated which can be used towards your treatments and medications.

Email all forms to: info@aspirerejuvenation.com

ASPIRE
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Patient Authorization for Delivery of Medications

I, _____ hereby authorize Aspire Rejuvenation Clinic staff to act on my behalf to accept medication delivery from an FDA licensed compounding pharmacy or the clinic's dispensing physician and deliver my medications and refills to me as prescribed by my physician.

I understand that medications can be picked up at the clinic or mailed to my provided address on a weekly basis (or as often as ordered by the physician). This authorization will remain active for the course of my treatment at this clinic or until I revoke it in writing.

No Guarantee of Services

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

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

Insurance Claims and Usage

I understand that if I use insurance for any lab-work or treatments that Aspire Rejuvenation is not responsible for any portion insurance may not cover. I agree to contact my insurance company to check my out of network benefits prior to authorizing Aspire Rejuvenation to use my health insurance.

No Refund Policy

Aspire Rejuvenation and all of its coinciding locations reserve the right to have a NO RETURN and NO REFUND policy.

_____

Patient Signature

Understanding your health record/information: What is in your healthcare record and how your protected health information ("PHI") is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record, may be used by our Practice, as follows:

- A basis for planning your care and treatment
- A means of communication among the healthcare professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as a paper-to-paper fax. Unencrypted text messaging or e-mailing may be used when requested and/or initiated by you. Please note that transmitting PHI via an unencrypted medium presents a risk that your PHI could be read by a third party.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating healthcare professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health-related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

Your Health Information Rights: Although your health record is the physical property of this Practice, the information belongs to you. You have the right to: Obtain a copy of this Notice of Privacy Practices

- Inspect and/or receive a copy of your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 of the Health Insurance Portability and Accountability Act of 1996 as subsequently amended ("HIPAA")
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this Practice

Our Responsibilities. We are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your PHI
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area and on our website at www.aspire-vitality.com At your request, we will provide you a revised Notice of Privacy Practices.

To Report a Problem

If you have questions, would like additional information or wish to report a problem, please contact the Practice's Privacy Officer. The HIPAA Privacy Officer for Aspire Vitality Inc is William Carswell, APRN-BC (407) 630-0778 or 7450 Dr. Phillips Blvd Suite 205 Orlando, FL 32819. The e-mail address is info@aspire-vitality.com.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy office or with the Office of Civil Rights, U.S. Department of Health and Human Services, by sending a letter to: 200 Independence Ave. S.W., Washington, D.C. 20201, calling 1.877.696.6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaint. There will be no retaliation for filing a complaint.

Treatment, Payment and Healthcare Operations: Treatment: Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with other healthcare providers involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A lab/bloodwork bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, HIPAA and this Practice, require the business associate to sign a Business Associate Agreement, protecting and securing your health information as required by Federal and State law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the Consent page).

Communication with family: Healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. (As governed by federal/state law and the Consent page).

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Sale of Business: We may disclose your health information in connection with the sale of all or part of our business. Other than this exception, we will not sell your PHI for remuneration without your authorization.

Authorization: We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, or other uses and disclosures not described in this notice.

ASPIRE
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HIPAA Acknowledgement and Consent

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

Patient Name: _____ DOB: _____ Date: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Work Phone Number: _____ Email Address: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes your spouse, children, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

☐ FIRST NAME ☐ PROPER SURNAME ☐ OTHER _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT PLAN, LAB RESULTS AND BILLING INFORMATION VIA:
(Please check all that apply)

☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ EMAIL ADDRESS

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:
(Please check all that apply)

☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ EMAIL ADDRESS

IF UNABLE TO REACH ME:

☐ Leave a detailed message ☐ Leave a message to return your phone call ☐ Do not leave a message

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:
(Please check all that apply)

☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ EMAIL ADDRESS

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient Name (Please Print) _____

Patient Signature _____

Or

Personal Representative Name (Please Print) _____

Signature of Personal Representative _____

Informed Consent for Hormone Replacement Therapy

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

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

_____ _____

Name DOB

_____ _____

Signature of patient Date

MEDICAL HISTORY AND SCREENING FORM

General Information

First Name _____ Middle Initial _____ Last Name _____

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

Phone Number _____

Alternate Number _____

Email _____

Street Address _____

City _____ State _____ Zip _____

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

☐ Black or African American ☐ Native Hawaiian ☐ Patient Declined ☐ Other**Family**

Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Sex: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Gender Neutral ☐

Which services, treatments and products are you interested in?

_____

_____

_____

Current Medical History

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

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

Do you now have or have you recently experienced?

- ☐ Chronic, recurrent or morning cough?
- ☐ Episodes of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?

☐ Stomach or intestinal problems such as recurrent heartburn, ulcers, constipation or diarrhea

☐ Significant vision or hearing problems?

☐ Recent change in a wart or mole?

☐ glaucoma or increased pressure in the eyes?

☐ exposure to long noises for long periods?

☐ an infection such as pneumonia followed by fever? significant unexplained weight loss?

☐ a fever which can cause dehydration and rapid heartbeat?

☐ a deep vein thrombosis (blood clot)?

☐ a hernia that is causing symptoms?

☐ foot or ankle sores that won't heal?

☐ persistent pain or problems walking after you have fallen?

☐ eye symptoms such as bleeding the retina or detached retina? cataract or lens transplant?

Female Patients Only:

☐ Menstrual Period Problems?

☐ Significant childbirth related problems?

☐ Urination when you cough, sneeze or laugh?

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

Are you on any type of hormone replacement therapy? ☐ YES ☐ NO

Which HRT Treatments are you currently on:

_____

_____

_____

List any prescription medications you are now taking: _____

_____

_____

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

_____

_____

Date of last complete physical examination: _____

- ☐ Normal
- ☐ Abnormal
- ☐ Never
- ☐ Can't Remember

Date of last chest x-ray: _____

- ☐ Normal
- ☐ Abnormal
- ☐ Never
- ☐ Can't Remember

Date of last echocardiogram (EKG or ECG): _____

- ☐ Normal
- ☐ Abnormal
- ☐ Never
- ☐ Can't Remember

List all surgeries in the last 10 years:_____

_____

_____

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

_____

_____

List hospitalizations including dates of and reasons for hospitalizations: _____

_____

_____

List all allergies to drugs: _____

_____

_____

Past Medical History

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

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

Comments: _____
_____

Hormone Health:

Check the boxes that pertain to you (Leave the others blank)

☐ Waking up in the morning not feeling refreshed and well rested

☐ Feeling like you need to take a nap in the middle of the day Needing to rely on caffeine or other stimulants

☐ Not getting an adequate full night's sleep

☐ Recent changes in your sex drive

☐ Difficulty with sexual arousal

☐ Changes in your enjoyment of life or loss of motivation Weight changes or difficulty maintaining your weight

☐ Recent difficulty managing your stress

☐ Past diagnoses of any hormone related condition

How did you hear about Aspire Rejuvenation Clinic?

_____

_____

_____

CREDIT CARD AUTHORIZATION FORM

CARD TYPE: ☐ **Master Card** ☐ **VISA** ☐ **Discover** ☐ **AMEX**

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____**SECURITY CODE:** _____

BILLING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

NAME ON CARD: _____

AUTHORIZED SIGNATURE: _____

By signing this form, you give us permission to keep above credit card on file and charge it for future orders. Card on file can be changed prior to your next transaction. You are authorizing Aspire Rejuvenation to charge and sign your card for future transactions.

***Aspire Rejuvenation** reserves the right to have NO RETURN and NO REFUND policy.

Please email back this form to the info@aspirerejuvenation.com

Future orders can be placed by calling the office at 407-233-4006