BOCA RATON CENTER FOR AGE MANAGEMENT

MITCHELL F. MATEZ, DO
200 GLADES ROAD – SUITE 300
BOCA RATON, FL 33432
(561) 953-5490 – PHONE
(561) 430-3616 - FAX

PATIENT INFORMATION

NAME	DOB	SEX
ADDRESS	CITY	
STATE	ZIP CODE	
HOME PHONE	CELL PHONE	EMAIL ADDRESS
SOCIAL SECURITY #	MARITAL STATUS	

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE #	RELATIONSHIP

MEDICAL INFORMATION

PHYSICIAN/INTERNIST	PHYSICIAN PHONE
PHARMACY NAME	PHARMACY PHONE

LIST ALL PREVIOUS SURGERIES/HOSPITALIZATIONS

ALLERGIES TO MEDICATIONS

☐ NO KNOWN DRUG ALLERGIES

CURRENT MEDICATIONS (PLEASE LIST ALL MEDICATIONS AND VITAMINS YOU ARE TAKING INCLUDING ORAL CONTRACEPTIVES)

MEDICATION	DOSAGE	HOW OFTEN

PERSONAL DATA

HEIGHT	WEIGHT	# OF CHILDREN

MEDICAL HISTORY

DATE OF LAST MAMMOGRAM	RESULT

HISTORY OF BREAST MASSES

FAMIILY HISTORY OF BREAST CANCER

PREVIOUS BIOPSIES

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INFORMED CONSENT
BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

I AUTHORIZE AND GIVE MY CONSENT TO MITCHELL MATEZ, DO, ALONG WITH OTHER ASSOCIATED PHYSICIANS, NURSES, TECHNICIANS AND ANY OTHER PERSONNEL OF BOCA RATON CENTER FOR AGE MANAGEMENT FOR THE EVALUATION, TREATMENT AND/OR PREVENTION OF THE SIGNS AND SYMPTOMS ASSOCIATED WITH THE PROCESS OF AGING VIA THE APPROPRIATE DIAGNOSTIC EVALUATION AND THE ADMINISTRATION OF BIOIDENTICAL HORMONES, DIETARY SUPPLEMENTS, AND ANY OTHER PHARMACEUTICAL/NEUTRACEUTICAL INTERVENTIONS DEEMED APPROPRIATE. I UNDERSTAND THAT GOAL AND POSSIBLE BENEFITS ARE TO ATTEMPT TO SLOW OR REVERSE THE PROCESSES ASSOCIATED WITH AGING THROUGH HORMONAL REPLACEMENT AND BALANCING, CONTROL OF OXIDATIVE STRESS, AND THE USE OF OTHER CLINICALLY SIGNIFICANT THERAPEUTIC AGENTS.

I HAVE BEEN FULLY INFORMED AND UNDERSTAND TO MY SATISFACTION THAT THIS TREATMENT MAY BE VIEWED BY MANY IN THE MEDICAL COMMUNITY AND THE FDA (FOOD AND DRUG ADMINISTRATION) AS NEW, EXPERIMENTAL, CONTROVERSIAL, AND/OR UNNECESSARY.

I HAVE BEEN FULLY INFORMED AND UNDERSTAND TO MY SATISFACTION THAT THE PROPOSED TREATMENTS MAY INVOLVE THE USE OF PRESCRIPTION MEDICATIONS SUCH AS BIOIDENTICAL HORMONES OR OTHER AGENTS THAT ARE APPROVED BY THE FDA FOR CERTAIN MEDICAL CONDITIONS *OTHER THAN SLOWING AND/OR REVERSING THE PROCESSES ASSOCIATED WITH AGING.*

I UNDERSTAND AND AM FULLY SATISFIED THAT THERE ARE RISKS (BOTH KNOWN AND UNKNOWN) TO ANY MEDICAL TREATMENT, THERAPY, OR PROCEDURE INCLUDING THE PROPOSED TREATMENT FOR SLOWING/REVERSING THE PROCESSES ASSOCIATED WITH AGING AND THAT THERE IS NO GUARANTEE OR ASSURANCE OF A SUCCESSFUL RESULT. I FULLY ACKNOWLEDGE AND ACCEPT THESE RISKS.

I UNDERSTAND AND AGREE TO FOLLOW THE PROPOSED TREATMENTS AND THERAPIES AS PRESCRIBED WITHOUT DEVIATION INCLUDING THE FACT THAT I MAY BE RESPONSIBLE FOR ADMINISTERING HORMONES OR OTHER DESIGNATED THERAPIES BY INJECTING, TAKING BY MOUTH, OR APPLYING TO MY SKIN, POSSIBLY MORE THAN ONCE A DAY, AND CONSENT TO PERIODICALLY HAVE MY BLOOD DRAWN, SALIVA ACQUIRED, OR HAVE URINE SPECIMENS OBTAINED FOR LABORATORY ANALYSIS AND MONITORING.

I ALSO AGREE TO TAKE/ADMINISTER THE HORMONE PREPARATIONS, DIETARY SUPPLEMENTS, AND OTHER DESIGNATED THERAPIES THAT HAVE BEEN PRESCRIBED FOR ME IN THE APPROPRIATE MANNER. *I HAVE COMPLETELY AND HONESTLY DISCLOSED MY COMPLETE MEDICAL HISTORY, INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS, NUTRITIONAL/DIETARY SUPPLEMENTS, AND ANY RECREATIONAL OR SOCIAL SUBSTANCES THAT I AM CURRENTLY TAKING OR PLAN TO TAKE WHILE UNDER THE THERAPIES PRESCRIBED. I ALSO UNDERSTAND THAT THE USE OF "SOCIAL SUBSTANCES" SUCH AS TOBACCO, ALCOHOL, AND RECREATIONAL OR "STREET" DRUGS MAY AFFECT MY THERAPY IN A SIGNIFICANTLY ADVERSE MANNER.*

I HEREBY CERTIFY THAT I AM UNDER THE CARE OF ANOTHER PHYSICIAN(S) FOR ANY OR ALL MEDICAL CONDITIONS AND WILL CONSULT WITH THIS PHYSICIAN(S) FOR ANY AND ALL MEDICAL SERVICES THAT I REQUIRE, REGARDLESS OF WHETHER IT IS CLASSIFIED AS AN EMERGENCY OR NON-EMERGENCY. I ALSO AGREE TO SEEK CARE FROM THIS PHYSICIAN AS IT MAY RELATE TO RECOMMENDED SCREENINGS FROM THE AMERICAN CANCER SOCIETY, AMERICAN HEART ASSOCIATION, OR ANY OTHER TRULY NOTABLE RESOURCE OF INFORMATION AS THESE ISSUES MAY RELATE TO CONCEPTS OF DISEASE PREVENTION OR ACUTE EMERGENCY, AND SUGGESTED EMERGENT OR PREVENTATIVE SCREENING TECHNIQUES, AS THESE MAY OR COULD RELATE TO ANY POSSIBLE CONTEMPLATED DISEASE PROCESSES OR CONCEIVABLE INTERVENTIONAL THERAPIES.

I UNDERSTAND THAT EACH HUMAN BEING IS UNIQUE AND MAY REACT DIFFERENTLY TO MEDICAL TREATMENTS. I HAVE BEEN FULLY INFORMED OF AND UNDERSTAND TO MY SATISFACTION THE KNOWN RISKS AND/OR POTENTIAL SIDE EFFECTS OF THE THERAPIES PRESCRIBED FOR ME. I ALSO HAVE BEEN INFORMED OF THE REASONABLE ALTERNATIVES TO THESE THERAPIES/PROCEDURES INCLUDING, BUT NOT LIMITED TO, LEAVING THE HORMONE LEVELS AS THEY CURRENTLY ARE AND TREATING AGE RELATED DISEASES AS THEY CLINICALLY APPEAR.

I HAVE BEEN FULLY INFORMED OF AND UNDERSTAND TO MY SATISFACTION THE PROPOSED THERAPIES AND/OR PROCEDURES, THE BENEFITS THEREOF, ANY POSSIBLE RISKS OR SIDE EFFECTS, AND THE ANTICIPATED OUTCOME. I HAVE HAD THE OPPORTUNITY TO ASK ALL QUESTIONS THAT I MAY HAVE IN THIS REGARD AND FULLY UNDERSTAND THE ANSWERS THAT I HAVE RECEIVED.

BY AFFIXING MY SIGNATURE TO THIS FORM I ATTEST TO FULLY READING AND UNDERSTANDING ALL OF THE POSSIBLY REPRESENTED IMPLICATIONS AND MEANINGS OF ITS WRITING AND EXPECTATIONS AND CONSENT TO THE PROPOSED LONG-TERM TREATMENT.

Patient Signature _____ Date _____

Physician Signature _____ Date _____

Witness Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION AND RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PATIENT COORDINATOR, STEPHANIE VOGEL (EXT 302).

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, OBTAIN PAYMENT, OR EXERCISE HEALTH CARE OPERATIONS AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION. "PROTECTED HEALTH INFORMATION" IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC DATA THAT CAN BE USED TO IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT, OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

WE ARE REQUIRED TO ABIDE BY THE TERMS OF THIS NOTICE OF PRIVACY PRACTICES. WE MAY CHANGE THE TERMS OF OUR NOTICE AT ANY TIME. THE NEW NOTICE WILL BE EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN AT THAT TIME. UPON YOUR REQUEST, WE WILL PROVIDE YOU WITH ANY REVISED NOTICE OF PRIVACY PRACTICES. YOU MAY OBTAIN THIS INFORMATION BY CALLING OUR OFFICE AND REQUESTING THAT A REVISED COPY BE SENT TO YOU IN THE MAIL OR ASKING FOR ONE AT THE TIME OF YOUR NEXT APPOINTMENT.

UNDERSTANDING YOUR HEALTH RECORDS/INFORMATION

EACH TIME YOU VISIT A HEALTHCARE PROVIDER, A RECORD OF YOUR VISIT IS MADE. TYPICALLY, THIS RECORD CONTAINS YOUR SYMPTOMS, EXAMINATION, TEST RESULTS, DIAGNOSIS, TREATMENT, AND A PLAN FOR FUTURE CARE OF TREAMENT. THIS INFORMATION, OFTEN REFERRED TO AS YOUR HEALTH OR MEDICAL RECORD, SERVES AS:

- THE BASIS FOR PLANNING YOUR CARE AND TREATMENT;
- A MEANS OF COMMUNICATIONS AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO YOUR CARE;
- A LEGAL DOCUMENT DESCRIBING THE CARE YOU RECEIVED;
- A MEANS BY WHICH YOU OR A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED;
- A SOURCE OF DATA FOR MEDICAL RESEARCH;
- A SOURCE OF INFORMATION FOR PUBLIC HEALTH OFFICIALS CHARGED WITH IMPROVING THE HEALTH OF THE NATION;
- A SOURCE OF DATA FOR FACILITY PLANNING AND MARKETING;
- A TOOL WITH WHICH WE CAN ACCESS AND CONTINUALLY WORK TO IMPROVE THE CARE WE RENDER AND THE OUTCOMES WE ACHIEVE.

UNDERSTANDING WHAT IS IN YOUR RECORD AND HOW YOUR HEALTH INFORMATION IS USED HELPS YOU TO:

- ENSURE IT'S ACCURACY;
- BETTER UNDERSTAND WHO, WHAT, WHEN, WHERE, AND WHY OTHERS MAY ACCESS YOUR HEALTH INFORMATION;
- MAKE MORE INFORMED DECISIONS WHEN AUTHORIZING DISCLOSURE TO OTHERS.

YOUR HEALTH INFORMATION RIGHTS

ALTHOUGH YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF THE HEALTHCARE PRACTITIONER OR FACILITY THAT COMPILED IT, THE INFORMATION WITHIN THAT RECORD BELONGS TO YOU. YOU HAVE THE RIGHT TO:

- REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OF YOUR INFORMATION;
- OBTAIN A PAPER COPY OF THE NOTICE OF INFORMATION PRACTICES UPON REQUEST;
- INSPECT AND OBTAIN A COPY OF YOUR HEALTH RECORD;
- REQUEST AN AMENDMENT OF YOUR HEALTH RECORD IF INACCURACIES ARE PRESENT;
- OBTAIN AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION;
- REQUEST COMMUNICATIONS OF YOUR HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS;
- REVORE YOUR AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION, EXCEPT TO THE EXTECT THAT ACTION HAS ALREADY BEEN TAKEN.

OUR RESPONSIBILITIES

THIS ORGANIZATION IS REQUIRED TO:

- MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION TO COMPLY WITH FEDERAL HEALTHCARE LAWS;

- PROVIDE YOU WITH A NOTICE AS TO OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO INFORMATION WE COLLECT AND MAINTAIN ABOUT YOU;
- ABIDE BY THE TERMS OF THIS NOTICE;
- NOTIFY YOU IF WE ARE UNABLE TO AGREE TO A REQUESTD RESTRICTION;
- ACCOMMODATE REASONABLE REQUESTS YOU MAY HAVE TO COMMUNICATE HEALTH INFORMATION BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS.

WE WILL NOT DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION EXCEPT AS DESCRIBED IN THIS NOTICE. IF YOU BELIVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU CAN FILE A COMPLAINT WITH OUR PRIVACY CONTACT OR WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES. THERE WILL BE NO RETALIATION FOR FILING A COMPLAINT. YOU MAY CONTACT OUR PRIVACY CONTACT, STEPHANIE VOGEL, FOR INFORMATION ABOUT THE COMPLAINT PROCESS.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

WE WILL USE YOUR HEALTH INFORMATION FOR TREATMENT. FOR EXAMPLE: INFORMATION OBTAINED BY A PRACTITIONER OR OTHER MEMBER OF YOUR HEALTHCARE TEAM WILL BE RECORDED IN YOUR RECORD AND USED TO DETERMINE THE COURSE OF TREATMENT THAT SHOULD WORK BEST FOR YOU. WE MAY PROVIDE YOUR PHYSICIAN OR A SUBSEQUENT HEALTHCARE PROVIDER WITH COPIES OF VARIOUS REPORTS THAT SHOULD ASSIST HIM OR HER IN TREATING YOU.

WE WILL USE YOUR HEALTH INFORMATION FOR PAYMENT. FOR EXAMPLE: A 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.

BUSINESS ASSOCIATES. THERE ARE SOME SERVICES PROVIDED IN OUR ORGANIZATION THROUGH CONTACTS WITH BUSINESS ASSOCIATES. EXAMPLES INCLUDE OUR BILLING SERVICE AND A COPY SERVICE WE USE WHEN MAKING COPIES OF YOUR HEALTH RECORD. WHEN THESE SERVICES ARE CONTRACTED, WE MAY DISCLOSE YOUR HEALTH INFORMATION TO OUR BUSINESS ASSOCIATES SO THAT THEY CAN PERFORM THE JOB WE'VE ASKED TO DO AND BILL YOU OR YOUR THIRD-PARTY PAYER FOR SERVICES RENDERED. TO PROTECT YOUR HEALTH INFORMATION HOWEVER, WE REQUIRE THE BUSINESS ASSOCIATE TO APPROPRIATELY SAFEGUARD YOUR INFORMATION.

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.

COMMUNICATION WITH FAMILY. HEALTH PROFESSIONALS, USING THEIR BEST JUDGEMENT, 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.

RESEARCH. WE MAY DISCLOSE INFORMATION TO RESEARCHERS WHEN THEIR RESEARCH HAS BEEN APPROVED BY AN INSTITUTIONAL REVIEW BOARD THAT HAS REVIEWED THE RESEARCH PROPOSAL AND ESTABLISHED PROTOCOLS TO ENSURE THE PRIVACY OF YOUR HEALTH INFORMATION.

FUNERAL DIRECTORS. WE MAY DISCLOSE HEALTH INFORMATION TO FUNERAL DIRECTORS CONSISTENT WITH APPLICABLE LAW TO CARRY OUT THEIR DUTIES.

ORGAN PROCUREMENT ORGANIZATIONS. CONSISTANT WITH APPLICABLE LAW, WE MAY DISCLOSE HEALTH INFORMATION TO ORGAN PROCUREMENT ORGANIZATIONS OR OTHER ENTITIES ENGAGED IN THE PROCUREMENT, BANKING, OR TRANSPLATATION OF ORGANS FOR THE PURPOSE OF TISSUE DONATIONS AND TRANSPLANT.

MARKETING. WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

FUNDRAISING. WE MAY CONTACT YOU AS PART OF FUNDRAISING EFFORTS.

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 THE 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 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.

FEDERAL LAW MAKES PROVISION FOR YOUR HEALTH INFORMATION TO BE RELEASED TO AN APPROPRIATE HEALTH OVERSIGHT AGENCY, PUBLIC HEALTH AUTHORITY OR ATTORNEY, PROVIDED THAT A WORK FORCE MEMBER OR BUSINESS ASSOCIATE BELIEVES IN GOOD FAITH THAT WE HAVE ENGAGED IN UNLAWFUL CONDUCT, OR HAVE OTHERWISE VIOLATED PROFESSIONAL OR CLINCAL STANDARDS AND ARE POTENTIALLY ENDANGERING ONE OR MORE PATIENTS, WORKERS, OR THE PUBLIC.

Patient Signature _____ Date _____

Witness Signature _____ Date _____