ANDROLOGIX™
HEALTH AND WELLNESS

Please complete & sign all pages and fax to (561) 658-6212

Medical Treatment Agreement

This agreement between _____ (Patient) and Andrologix Health and Wellness, LLC. and their parent company Nationwide Synergy, Inc. (Andrologix) establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. Andrologix and Patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/physician relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

THE PATIENT ACCEPTS AND AGREES TO THE FOLLOWING CONDITIONS:

1. I understand that the medical treatment offered by Andrologix and their Physician(s) is not accompanied by any claims, guarantees, promises or warranties.
2. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood/lab work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
3. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it's against the law to do so.
4. I will immediately report any adverse side effects related to the use of my medication to Andrologix and discontinue use until advised to resume usage by Andrologix.
5. I understand that the Andrologix Physician (MD) and/or Licensed Physician's Assistant (PA-C) are available for questions and/or concerns during normal business hours throughout the course of my treatment.
6. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
7. I agree that these medications are for my personal use only and no other purpose and I will not share, sell, or trade my medications.
8. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.
9. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I agree to contact Andrologix 4-6 weeks into the start of my therapy (and every 3 months thereafter) to arrange for any follow-up blood testing and/or an office visit/consultation as required by the Andrologix physician.
11. I agree and understand that my fees include a one hundred dollar appointment deposit which will be applied to the cost of my examination, blood work, or therapy. To cancel an appointment, I must email my cancellation request to DianeV@pbpmed.com at least 48 hours prior to my scheduled appointment time or the $100 deposit will not be refunded.
12. I agree that the Andrologix patient/physician relationship is not intended to replace the existing relationship with my current primary care provider (PCP) and my Andrologix treatment will be in conjunction with the care provided by my current PCP.

_____
Patient's Signature

_____ _____
Patient's Printed Name Date

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Most patients are very anxious to hear the results of their lab tests or other determinations made by our medical staff regarding their treatment. Due to a physician's schedule, communication of the results, especially if they are within normal ranges, is sometimes delayed. Although all Andrologix Health and Wellness personnel, both professionals and non-professionals, are part of the Health Care Operations of the practice, and therefore do not require a specific HIPAA consent form, Andrologix Health and Wellness takes the confidentiality of your personal health information very seriously and does not permit its personnel who are not directly involved in your medical assessments and treatment with access to your medical records without your written consent. By signing this form, you will give permission to allow your Andrologix advisor, or other administrative staff member, to communicate to you via phone, email, in writing, or in person, protected health information pertaining to your medical care.

This consent form does **not** allow Andrologix Health and Wellness to share your health information with any third-party for any reason. **It simply authorizes our administrative staff to convey information from our medical staff to you, at your request.** I further understand that administrative staff **cannot** answer specific questions about the meaning of the results or treatment modalities, and if I have such questions after receiving the results, the administrative staff will have a physician or other qualified health professional contact me to answer my questions.

Authorization for Andrologix to Release Health Information to Myself

I, the undersigned patient, hereby give my consent for Andrologix Health and Wellness LLC, their parent company Nationwide Synergy, Inc. (Andrologix), and their non-medical professional and administrative staff to disclose my protected health information (PHI) to me pertaining to my medical results and treatment.

With this consent, my Andrologix advisor, or other administrative staff, may communicate to me by phone, email, in writing, or in person, information that assists the practice in carrying out operations related to my treatment; such as, appointment reminders, billing issues, and communications related to my clinical care, including laboratory test results. I acknowledge that such advisor or staff cannot answer specific questions about the results or course of my treatment, and that I can request a physician or other health professional to contact me to answer my questions.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that this form is not required under the HIPAA privacy rule, but if I choose not to consent, or later revoke consent, Andrologix may be unable to continue to provide treatment to me, but they will not do so without affording me a reasonable time, not longer than thirty days, to obtain a successor physician/practice.

_____
Patient's Signature

_____ _____
Patient's Printed Name **Date**

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Credit Card Authorization

• Please complete and sign Section A OR Section B.

A I authorize Andrologix Health and Wellness' parent company Nationwide Synergy, Inc. to keep my signature on file and to charge my credit card account, on an ongoing basis for amounts I owe. Charges will appear on my statement as "Nationwide Synergy, Inc." I understand that this authorization is valid for two years from the below date unless I cancel the authorization through written notice. I also agree to contact the merchant if there are any changes to my credit card account information.

Cardholder Name: _____
FIRST NAME LAST NAME

Cardholder Address: _____
STREET CITY STATE ZIP

If your shipping address is different from your billing address, please enter it here:

Shipping Address: _____
STREET CITY STATE ZIP

Account Number: _____ _____ _____
CARD NUMBER SECURITY CODE EXPIRATION DATE

_____ _____
Card Holder Signature Date

OR

B I don't want my signature on file and understand that I will have to provide my complete credit card information every time I make a purchase or reorder my prescriptions. These purchases will appear on my statement as "Nationwide Synergy, Inc." Andrologix Health and Wellness' parent company.

_____ _____
Card Holder Signature Date

Remember, in order to be considered complete, you must fill-out and sign one of the above sections.