UTOPIA Wellness
110 State Street East, Suite A, Oldsmar, Florida 34677 • UtopiaWellness.com • 727.799.9060

NEW PATIENT INFORMATION

Please print all information in the spaces provided. Be sure to complete and sign the statement on the bottom of this form.

Last name: _____ First Name: _____ M.I _____
Local Address: _____
City: _____ State: _____ Zip: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Email Address: _____
Employer Name and Address: _____
SSN: _____ Date of Birth: _____ Age: _____
Sex (check one): ☐ Male ☐ Female Height: _____ Weight: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____
Primary Care Physician: _____ Phone: _____

Name and phone number of the person to contact in case of emergency:

_____

Please tell us how you heard about us:

☐ Friend/Family ☐ Physician Referral ☐ Utopia Wellness Website
☐ Google ☐ Cancer Free by Bill Henderson ☐ Other: _____

	Concern (rank by priority) Example: Headache	Onset 1/1/2016	Frequency 4 x Weekly	Severity Moderate
1.				
2.				
3.				
4.				

I certify the information provided above is true and correct to the best of my knowledge. I understand payment is expected the same day as services are rendered, and that Utopia Wellness accepts Visa, MasterCard, Discover, and Cash. CareCredit offers 0% financing for those who qualify. Utopia Wellness accepts personal checks with a credit card as a backup payment method. If the bank returns the check unpaid, the credit card will be charged to full amount plus an additional $40 returned check fee. I understand and agree to these terms and conditions.

I will pay by: (check one)

☐ Cash ☐ Check ☐ Credit Card ☐ CareCredit

_____ _____
Patient signature or Guardian Date

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PATIENT HISTORY

Are you currently undergoing medical treatment? ☐Y ☐N If "yes" please describe.	
Condition:	**Symptoms:**

	Medications	Prescribing Doctor	Strength	Times Per Day	How Long
a.					
b.					
c.					
d.					
e.					

Other Physicians' Information	
	Name
Primary Care	
Specialist	
Gynecologist	
Other	

Are medical reports / x-rays available? ☐Y ☐N If "YES" please describe:

Have you ever been hospitalized? ☐Y ☐N If "YES" please describe:

Date:
Date:
Date:

FAMILY HISTORY			
Relative	**Good Health**	**Poor Health**	**If deceased, give age & cause of death**
Father			
Mother			
Brother			
Brother #2			
Brother #3			
Sister			
Sister #2			
Sister #3			
Spouse			
Child			
Child #2			
Child #3			

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1. HAVE YOU EVER HAD:

Yellow Jaundice	☐Y ☐N	Rheumatic Fever	☐Y ☐N	Diabetes	☐Y ☐N
Anemia	☐Y ☐N	Gall Stones	☐Y ☐N	Gall Bladder Removed	☐Y ☐N
Liver Problems	☐Y ☐N	Rheumatic Fever	☐Y ☐N		

2. IMMUNE SYSTEM:

Candida Albicans (Yeast)	☐Y ☐N	Tuberculosis (TB)	☐Y ☐N	Recurring Infections	☐Y ☐N
AIDS	☐Y ☐N	HIV Testing Date:		Result: ☐Pos ☐Neg	

3. IMMUNIZATIONS: Please indicate date of immunization:

Smallpox		Tetanus		Flu		Mumps	
Polio		Typhoid		Measles		Other	

4. MEDICINES USED IN THE PAST THREE (3) MONTHS:

Antibiotics	☐Y ☐N	Antacid	☐Y ☐N	Antispasmodic	☐Y ☐N
Laxatives	☐Y ☐N	Antihistamines	☐Y ☐N	Muscle Relaxant	☐Y ☐N
Tranquilizer	☐Y ☐N	Sedative	☐Y ☐N	Sleep Pill	☐Y ☐N
Antidepressant	☐Y ☐N	Stimulant	☐Y ☐N	Diet/Weight Control	☐Y ☐N
Water Pill	☐Y ☐N	Heart Medicines	☐Y ☐N	Blood Pressure	☐Y ☐N
Cortisone	☐Y ☐N	Inhaler	☐Y ☐N	Thyroid Hormone	☐Y ☐N
Hormone	☐Y ☐N	Contraceptives	☐Y ☐N	Anti-inflammatory	☐Y ☐N
Asthma Meds	☐Y ☐N	Pain pill/Analgesic	☐Y ☐N	Nasal Decongestant	☐Y ☐N
Aspirin	☐Y ☐N	Anti-Seizure	☐Y ☐N	B12 Injections	☐Y ☐N
Steroids	☐Y ☐N	Cholesterol Meds	☐Y ☐N	Cough/Cold Meds	☐Y ☐N
Anti-Ulcer Meds	☐Y ☐N	Liver Meds	☐Y ☐N	Potassium Pill	☐Y ☐N

5. DIGESTIVE PROBLEMS:

Flatulence	☐Y ☐N	Heartburn	☐Y ☐N	Nausea	☐Y ☐N
Bloating	☐Y ☐N	Belching	☐Y ☐N	Vomiting	☐Y ☐N
Gas	☐Y ☐N	Reflux	☐Y ☐N	Cramps	☐Y ☐N

6. VITAMINS & MINERALS TAKEN IN THE LAST THREE MONTHS:

Name	Qty	Times per week

7. FOOD INTOLERANCE / ALLERGY:

Milk	☐Y ☐N	Wheat	☐Y ☐N	Eggs	☐Y ☐N	Nuts	☐Y ☐N
Other:							

8. MEDICINE & OTHER ALLERGIES:

Codeine	☐Y ☐N	Penicillin	☐Y ☐N	Morphine	☐Y ☐N
Antibiotics	☐Y ☐N	Animal dander	☐Y ☐N	Dust	☐Y ☐N
Iodine	☐Y ☐N	Shellfish	☐Y ☐N	Gadolinium (contrast used in MRI)	☐Y ☐N
Pollen	☐Y ☐N	Latex	☐Y ☐N	Describe allergic symptoms:	

9. ALLERGIC SYMPTOMS:

a) Skin (Describe) _____
b) Hay Fever _____
c) Asthma _____
d) Nasal _____
e) Other: _____

10. STOMACH PROBLEMS:

Cramps	☐Y ☐N	Spastic Colon	☐Y ☐N	Crohn's Disease	☐Y ☐N
Pains	☐Y ☐N	Ulcer	☐Y ☐N	Diverticulitis	☐Y ☐N
Hiatal	☐Y ☐N	Other:			

11. BOWEL MOVEMENTS: **Frequency:** **times per week**

Chronic	☐Y ☐N	Difficult Release	☐Y ☐N	Foul Smelling	☐Y ☐N
Hemorrhoids	☐Y ☐N	Irregular	☐Y ☐N	Hard Solid Stool	☐Y ☐N
Laxative Use	☐Y ☐N	Stool Softeners	☐Y ☐N	Watery	☐Y ☐N
Bile	☐Y ☐N	Frothy	☐Y ☐N	Oily	☐Y ☐N
Fatty	☐Y ☐N	IBS	☐Y ☐N	IBD	☐Y ☐N

12. HYPOGLYCEMIA:

Fatigue	☐Y ☐N	Energy Dives	☐Y ☐N	Shakiness	☐Y ☐N
Fade Out	☐Y ☐N	Sweating Spells	☐Y ☐N	Drowsiness	☐Y ☐N
Dizzy Spells	☐Y ☐N	Frequent Yawning	☐Y ☐N	Tinnitus	☐Y ☐N

13. STRESS:

Gout	☐Y ☐N	Anxiety	☐Y ☐N	Sleeplessness	☐Y ☐N

14. CRAVINGS:

Water	☐Y ☐N	Coffee/Tea	☐Y ☐N	Salt	☐Y ☐N
Sweets	☐Y ☐N	Tobacco	☐Y ☐N	Alcohol	☐Y ☐N
Carbs	☐Y ☐N	Other:			

15. EMOTIONAL AND MENTAL:

Depression	☐Y ☐N	Anxiety	☐Y ☐N	Weepiness	☐Y ☐N
Sweating	☐Y ☐N	Irritability	☐Y ☐N	Impatience	☐Y ☐N
Temper	☐Y ☐N	Anger	☐Y ☐N	Autism	☐Y ☐N
Schizophrenia	☐Y ☐N	Epilepsy	☐Y ☐N	Neurosis	☐Y ☐N

16. NERVES:

Tingling	☐Y ☐N	Pins and Needles	☐Y ☐N	Numbness	☐Y ☐N
Twitching	☐Y ☐N	Tics & Tremors	☐Y ☐N	Jerks	☐Y ☐N
Poor Circulation	☐Y ☐N	Neuralgia	☐Y ☐N	Clumsy	☐Y ☐N
Shooting Pains	☐Y ☐N	Tired Feet	☐Y ☐N	Neuritis	☐Y ☐N
Burning Feet	☐Y ☐N	Paralysis	☐Y ☐N	Parkinson's Disease	☐Y ☐N

17. CHOLESTEROL:

High Cholesterol	☐Y ☐N	High Triglycerides	☐Y ☐N

18. CARDIOVASCULAR:

High Blood Pressure	☐Y ☐N	Angina	☐Y ☐N	Phlebitis	☐Y ☐N
Low Blood Pressure	☐Y ☐N	Irregular Pulse	☐Y ☐N	Atherosclerosis	☐Y ☐N
Heart Disease	☐Y ☐N	Edema Swelling	☐Y ☐N	Palpitation	☐Y ☐N
Coronary Thrombosis	☐Y ☐N	Cold Hands	☐Y ☐N	Cold Feet	☐Y ☐N

19. VENOUS PROBLEMS:

Hemorrhoids	☐Y ☐N	Varicose Veins	☐Y ☐N	Easy Bruising	☐Y ☐N
Nose Bleeds	☐Y ☐N	Slow Healing	☐Y ☐N		

20. ARE YOU PREGNANT? ☐Y ☐N

Nausea	☐Y ☐N	Pre-eclampsia	☐Y ☐N	Eclampsia	☐Y ☐N
Fluid Retention	☐Y ☐N	Ankle Swelling	☐Y ☐N	Palpitation	☐Y ☐N

21. MENSTRUAL AND GYNECOLOGIC PROBLEMS:

PMS	☐Y ☐N	Cramps	☐Y ☐N	Heavy Flows	☐Y ☐N
Normal Flow	☐Y ☐N	Menopause	☐Y ☐N	No Menstrual Cycle	☐Y ☐N
Vaginal Discharge	☐Y ☐N	Vaginal Infection	☐Y ☐N	Vaginal Inflammation	☐Y ☐N
Itching	☐Y ☐N	Foul Smelling	☐Y ☐N	Birth Control Method	☐Y ☐N
Hysterectomy	☐Y ☐N	Date		Date of last gynecological exam	

22. HORMONE AND SEX PROBLEMS – WOMEN:

Infertility	☐Y ☐N	Lack of Sex	☐Y ☐N	Lack of Orgasm	☐Y ☐N
Hot Flashes	☐Y ☐N	Lack of Sexual Secretions	☐Y ☐N		

23. HORMONE AND SEX PROBLEMS – MEN:

Impotency	☐Y ☐N	Lack of Sex Interest	☐Y ☐N	Erectile Dysfunction	☐Y ☐N
Infertility	☐Y ☐N	Lack of Libido	☐Y ☐N		

24. DO YOU HAVE KIDNEY PROBLEMS? ☐Y ☐N If "YES" please describe:

25. HEADACHES:

Symptoms		Duration		Frequency	
Recurring	☐Y ☐N	Frontal Headache	☐Y ☐N	Eye Aches	☐Y ☐N
Temple Aches	☐Y ☐N	Migraine	☐Y ☐N	Migraine w/Nausea	☐Y ☐N
After Stress	☐Y ☐N	After Exertion	☐Y ☐N	Back of Head/Neck	☐Y ☐N

26. SLEEP:

Light	☐Y ☐N	Heavy	☐Y ☐N	Difficult to Fall Off	☐Y ☐N
Restless	☐Y ☐N	Dreamless	☐Y ☐N	Disturbing Dreams	☐Y ☐N
Sleep Aids	☐Y ☐N	Name:		Frequent Wakening	☐Y ☐N

27. ENERGY:

Low	☐Y ☐N	High	☐Y ☐N	Fatigue	☐Y ☐N
Listless	☐Y ☐N	Lack of Drive	☐Y ☐N		

28. MUSCLE AND LIGAMENT PROBLEMS:

Stiffness	☐Y ☐N	Aching Muscles	☐Y ☐N	Muscle Weakness	☐Y ☐N
Weak Ligaments	☐Y ☐N	Leg Cramps	☐Y ☐N	Myasthenia Gravis	☐Y ☐N
Shin Splints	☐Y ☐N	Tennis Elbow	☐Y ☐N	Ligament Problems	☐Y ☐N
Loss of Mass	☐Y ☐N	Muscle Movement	☐Y ☐N		

29. BONE AND JOINT PAIN:

Joint Pain	☐Y ☐N	Lower Back Pains	☐Y ☐N	Stiffness	☐Y ☐N
Swollen Joints	☐Y ☐N	Spine Curvature	☐Y ☐N	Osteoporosis	☐Y ☐N

30. HISTORY OF WEIGHT PROBLEMS:

Symptoms				Duration	
Bulimia	☐Y ☐N	Anorexia	☐Y ☐N	Frequent Dieting	☐Y ☐N
Overweight	☐Y ☐N	Underweight	☐Y ☐N	Fluid Retention	☐Y ☐N
Diet Pills	☐Y ☐N	Compulsive Eating	☐Y ☐N		

31. TONGUE:

Dry	☐Y ☐N	Sore	☐Y ☐N	Grooved	☐Y ☐N
Inflamed	☐Y ☐N	Split	☐Y ☐N	Smooth Shiny	☐Y ☐N
Pink	☐Y ☐N	Purplish	☐Y ☐N	Brilliant Red	☐Y ☐N
Furry Coated	☐Y ☐N	Bile Taste	☐Y ☐N	Metallic Taste	☐Y ☐N
Loss of Taste	☐Y ☐N	Enlarged	☐Y ☐N		

32. MOUTH:

Canker Sores	☐Y ☐N	Blisters	☐Y ☐N	Split Corners	☐Y ☐N
Bleeding Gums	☐Y ☐N	Dry Cracked Lips	☐Y ☐N	Tender Puffy Gums	☐Y ☐N

33. TEETH:

Root Canal	☐Y ☐N	White Patches	☐Y ☐N	Discolored	☐Y ☐N
Loose	☐Y ☐N	Grinding Teeth in Sleep	☐Y ☐N	Fillings	☐Y ☐N
Hot/Cold Sensitive	☐Y ☐N	Number of Extractions	☐Y ☐N		

34. EARS:

Vertigo	☐Y ☐N	Recurring Earaches	☐Y ☐N	History of Grommets	☐Y ☐N
Motion Sickness	☐Y ☐N	Tinnitus	☐Y ☐N	Blocked Ears	☐Y ☐N
Hearing Loss	☐Y ☐N				

35. EYES:

Cataracts	☐Y ☐N	Glaucoma	☐Y ☐N	Macular Degeneration	☐Y ☐N
Pink Eye	☐Y ☐N	Watering	☐Y ☐N	Eye Discharge	☐Y ☐N
Blurred Vision	☐Y ☐N	Lack of Eye Fluid	☐Y ☐N	Itchy	☐Y ☐N
Sandy Feeling	☐Y ☐N	Retinopathy	☐Y ☐N	Burning	☐Y ☐N
Eye Surgery	☐Y ☐N				
Eye Medication	☐Y ☐N				

36. NASAL / THROAT:

Sinus Problems	☐Y ☐N	Postnasal Drip	☐Y ☐N	Phlegm	☐Y ☐N
Itchy	☐Y ☐N	Hoarse	☐Y ☐N	Voice Change	☐Y ☐N
Difficulty Swallowing	☐Y ☐N				

37. NAILS:

Ridges	☐Y ☐N	White Spots	☐Y ☐N	Peel	☐Y ☐N
Break Easily	☐Y ☐N	Soft	☐Y ☐N		

38. HAIR AND SCALP:

Falling Out	☐Y ☐N	Dry Hair	☐Y ☐N	Brittle/Breaks Easily	☐Y ☐N
Seborrhea	☐Y ☐N	Dandruff	☐Y ☐N	Dry Scalp	☐Y ☐N
Thin	☐Y ☐N	Oily	☐Y ☐N		

39. SKIN PROBLEMS:

Dry	☐Y ☐N	Scaly	☐Y ☐N	Acne	☐Y ☐N
Eczema	☐Y ☐N	Psoriasis	☐Y ☐N	Itchy	☐Y ☐N
Boils	☐Y ☐N	Vitiligo	☐Y ☐N	Sweaty	☐Y ☐N
Pigmentations	☐Y ☐N	Brow Spots	☐Y ☐N		

40. SMOKING:

☐Never ☐No Longer Previously per Day _____ ☐Current Current per Day _____

41. CHEST AND LUNGS:

Cough	☐Y ☐N	Emphysema	☐Y ☐N	Bronchitis	☐Y ☐N
Pleurisy	☐Y ☐N	Painful Breathing	☐Y ☐N	Shortness of Breath	☐Y ☐N
Hyperventilation	☐Y ☐N	Respiratory Infection	☐Y ☐N	COPD	☐Y ☐N

42. FEET:

Athlete's Feet	☐Y ☐N	Fungal Infection	☐Y ☐N	Bunions	☐Y ☐N
Corns	☐Y ☐N	Toe Deformities	☐Y ☐N	Painful Feet	☐Y ☐N
Callouses	☐Y ☐N	Thickened Nails	☐Y ☐N	Itching	☐Y ☐N

43. ACTIVITY AND EXERCISE: Please describe your activities and exercise

Description	Frequency (per week)	Duration

44. LIST ANYTHING ELSE THAT YOU HAVE EXPERIENCED THAT MAY HELP YOUR MEDICAL TEAM:

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110 State Street East, Suite A, Oldsmar, Florida 34677 • UtopiaWellness.com • 727.799.9060

HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact the Privacy Officer.
Effective 01/01/16

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to that of the records of your care generated by our office, or collected by our office, for your medical care.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your right and certain obligations we have regarding the use and disclosure of medical information.

The Law requires us to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use your medical information with family members, physician, clergy or others we use to provide services that are part of your care, medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other office personnel who are involved in taking care of you at the office. We also may disclose medical information about you to people outside the office who may be involved in your medical care after you leave our office, such as physicians, family members, clergy, or others we use to provide services that are part of your care.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed, and payment may be collected from you.
- **For Health Care Operations**. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and see that all of our patients receive quality care.
- **Appointment Reminders and Call Backs.** We may use and disclose medical information to contact you as a reminder that you have an appointment. We may also use information to contact you regarding lab results, referrals, prescriptions, or procedure results.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved with your medical care. We may also give information to someone who helps pay for your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We will disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement, eye or tissue transplantation, or to an organ donor bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities may include: the prevention or control of disease, report births and deaths, report child abuse or neglect, to notify people of recalls, and to report reactions to medications.
- **Health Oversight Activities.** We may disclose medical information to health oversight agencies for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else in dispute.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order, to identify or locate a suspect, witness or missing person, about the victim of a crime, about a death believed to be a result of criminal conduct, about criminal conduct at the hospital, and in emergency circumstances to report a crime.

- **Coroners, Medical Examiners, and Funeral Directors.** We may release medical information to a coroner or medical examiner.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you.

- **Right to Inspect and Copy**. Your designated record set is a group of records we maintain that includes medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management, as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information retained by our office, except for (a) psychotherapy notes, (b) information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your requests.

  We may deny your request to inspect and copy certain personal health information as permitted or required by law.

  We will reasonably attempt to accommodate any request for personal health information, to the extent possible, by giving you access to other personal health information after excluding the information as to which we have ground to deny access.
  Upon denial, we will provide you written denial specifying the basis for denial and how to file a complaint with us.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. You should contact our Security Officer to request an amendment. This request should be an amendment. This request should be in writing and mailed to our address at 110 State Street East, Suite A, Oldsmar, FL 34677, Attention: Privacy Officer. We have the right to deny amendment if (a) we determine that the information or record that is the subject of the request was not created by us unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We require that you submit written request and provide a reason to

support the requested amendment. Upon denial, we will provide you with a written denial specifying the basis for denial.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you that have not been outlined in the use or disclosures section of our privacy notice.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You must take your request in writing to our office at:

110 State Street East, Suite A, Oldsmar, FL 34677
Attention: Privacy Officer

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You must make your request in writing to the Director of Health Information Services.
- **Right to a Paper Copy of this Notice.** You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, ask the Patient Registration clerk.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the right-hand corner, the effective date. You will be given a copy of this notice when you come in for an appointment when there are changes to this version of our privacy notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services in writing to (200 Independence Avenue, S.W. Room 509F, Washington DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). To file a complaint with our office, contact the Privacy Officer at (727) 799-9060. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your

permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

If our privacy and security measures or systems are breached in any way, we will notify you.

If you willingly would like us share your information with a friend or family member, please provide us with their name, relationship to you and their telephone number.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I have read and understand the terms of this HIPPA Notice of Privacy Practices for Utopia Wellness and have been provided a copy of same.

Date

Beneficiary or his/her legal representative

UTOPIA Wellness
110 State Street East, Suite A, Oldsmar, Florida 34677 • UtopiaWellness.com • 727.799.9060

Medicare Opt Out Agreement

This agreement is between Carlos M. Garcia, M.D. whose principal place of business is 110 State St., Suite A, Oldsmar, FL 34677 and _____ who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997.. The physician has opted out of the Medicare program indefinitely.

In exchange for the services, the patient agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.

Medicare does not apply ☐

_____
Date

_____ _____
Beneficiary or his/her legal representative Witness

UTOPIA Wellness
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Cancellation Policy

I understand that I must cancel and/or reschedule an appointment by giving 24 hours advance notice.

I understand that Utopia Wellness reserves the right to charge $25.00 for missing an appointment and that if I am more than 10 minutes late, I could possibly be considered to have missed my appointment.

I understand that it is ultimately my responsibility for keeping my scheduled appointments.

_____
Date

_____
Beneficiary or his/her legal representative