

PharmXHealthOne Integrated Medical Clinic

New Patient Registration, Health History, HIPAA Notice, Consent & Policy Acknowledgment

2828 S Seacrest Blvd, Suite 216, Boynton Beach, FL 33435 | Phone: (561) 778-8121

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Online completion is preferred; paper copies and assistance are available. Review the HIPAA notice and applicable consents and policies before signing. Registration does not replace treatment-specific consent or optional authorizations. Ask PHO if you cannot access a document.



Full forms, consents and policies
Scan for new-patient documents on
pharmxhealthone.com

1. Patient Demographics and Contact Information

Legal first name	Middle initial	Legal last name	Preferred name
Date of birth	Age	Sex assigned at birth	Gender identity (optional)
Mobile phone	Alternate phone	Email address	
Street address	Apt / suite	City	State / ZIP
Race: ___Asian ___Black or African American ___Native American ___White / Caucasian Other: _____			
Marital status: single, married, divorced, widowed, other	Children? How many?	Occupation:	Employment Status: (Full-time, part-time, unemployed)

2. Emergency Contact and Responsible Party

Emergency contact name	Relationship	Primary phone	Voicemail permission: Yes / No
Responsible party / guardian, if applicable	Relationship to patient	Phone	Email
Billing address if different	Authority documentation provided?	Authorized person to discuss care?	Name/phone or use separate authorization
RELEASE OF INFORMATION: Listing an emergency contact or responsible party does not authorize full record access. Use the separate, completed Authorization to Release or Discuss Medical Information when required. PHO will verify representative authority and comply with applicable confidentiality law.			

3. HIPAA Notice of Privacy Practices Acknowledgment

By signing, you acknowledge receipt or availability of PHO's full HIPAA Notice of Privacy Practices. HIPAA, 45 CFR 164.520, requires the notice and a good-faith effort to obtain receipt acknowledgment. PHO will protect applicable PHI and follow its notice. You have the right to request a paper copy. This signature does not waive rights or authorize marketing. Declining this receipt signature alone does not bar care.

Patient/Legal Representative Signature: _____ **Date:** _____

Print Name: _____

4. Reason for Visit / Services of Interest

☐ Weight loss / GLP-1 options ☐ Hormone / HRT evaluation ☐ Lab review / advanced testing ☐ Functional/preventive care ☐ IV/injection therapy ☐ Peptides/wellness ☐ Aesthetic/body-contouring ☐ Pain/EPAT ☐ Supplements ☐

Other: _____

Main concern or goal in one sentence: _____

5. Abbreviated Health History - Check Any That Apply

Check every condition that applies and explain checked items below. Mark None only if none of the listed conditions apply: ____ None.

☐ High blood pressure	☐ High cholesterol	☐ Heart disease/heart attack	☐ Stroke/TIA
☐ Blood clots/DVT/PE	☐ Diabetes/insulin resistance	☐ Thyroid disease	☐ Kidney disease
☐ Liver/gallbladder disease	☐ Cancer	☐ Autoimmune disease	☐ Asthma/COPD
☐ Sleep apnea	☐ Seizure/neurologic disorder	☐ Migraine	☐ Anemia/bleeding disorder
☐ Chronic pain/arthritis	☐ GI/colon disease	☐ Mental health condition	☐ Substance use disorder
☐ Eating disorder	☐ STI/HIV/communicable disease	☐ Pregnant/breastfeeding	☐ Implanted device/pacemaker
Current prescriptions, hormones, injections, blood thinners, insulin, controlled substances, or compounded meds:			
Supplements, nutraceuticals, peptides, OTC medications, or wellness products:			
Allergies and reactions: No known allergies			
Surgeries, procedures, hospitalizations, implanted devices, or anesthesia reactions:			
Family/social history concerns: tobacco/nicotine, alcohol, cannabis/recreational drugs, cancer, heart disease, diabetes, blood clots, mental health, or other:			

5. Health History - Additional Information and Intake Process

This screen supplements your clinical history. Provide details that do not fit on an attached sheet or through the approved patient system. If further history, records, examination, or tests are required, PHO will explain what you need to complete before care proceeds. A checked item does not itself establish eligibility or treatment.

Primary care provider and last visit:	Preferred pharmacy / phone:
Dates of most recent labs / where obtained:	Recent health changes or current symptoms:
Pregnancy/breastfeeding or possibility of pregnancy:	Details of checked conditions and current treatment:

Bring a driver's license or passport, medication list, and recent labs if available. Bring an insurance card if outside laboratory billing can be used. PHO is cash-pay for its own services. When appropriate and agreed, your in-person assessment will include SECA; preliminary measurements do not replace provider evaluation. Relevant labs are required before general-health, HRT, and anti-aging consultations; if your provider determines that a weight-loss evaluation can safely start without labs, PHO will proceed, and you will need to complete any testing required for safety.

Continue to page 3 for refund and scheduling terms, patient-specific ordering, care-communication authorization, and your signature. Complete the separate applicable consents in your patient packet.

PHO New Patient Registration - Policy Acknowledgment

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Patient legal name: _____ Date of birth: _____

6. Refund, Return, and Product Policy - Important

PHO's final-sale and no-refund terms are clinic business policies, not a government requirement that every purchase be nonrefundable. PHO does not voluntarily accept returns of medications or healthcare products or refund purchased products after the applicable authorized purchase or patient-specific order commitment. Consultations, assessments, procedures, and treatments already partially or fully provided are not voluntarily refunded. Patient-specific ordering, professional time, preparation, pharmacy and supplier costs, labeling, shipping, refrigeration, sterility, and uncertain product integrity can make costs nonrecoverable. Not all medications are compounded.

PHO does not keep standing unassigned medication inventory. Appropriate history and assessment, laboratory review when required, professional treatment determination, informed consent, and payment precede an individual order as applicable. The written order or invoice must identify what is purchased, the price, fulfillment terms, and when the commitment becomes noncancelable. Consultation fees are due immediately after consultation. A selected treatment package is paid at purchase unless PHO approves a written installment plan with at least 50 percent down and disclosed remaining payments.

Change of mind or an undesired outcome does not alone create a voluntary refund for authorized purchases or services already provided. Prepayments for unprovided services, unavailable products, or unused package portions are governed by the actual agreement and applicable law, not an automatic forfeiture. Florida section 456.0625 and section 408.12 where applicable require qualifying patient overpayments to be refunded within 30 days after determination. PHO will correct required overpayments and lawful billing errors. Unauthorized charges, duplicate charges, Good Faith Estimate remedies, and other non-waivable rights remain protected. You will need to promptly report damaged products, fulfillment concerns, or suspected billing errors; a goodwill exception is not a substitute for a legally required remedy.

Patient initials acknowledging section 6: _____ Date: _____

7. Global Consent, Communication, and Policy Acknowledgment

You will need to cancel an appointment at least 24 hours before its scheduled start time. PHO will charge \$25 for a cancellation less than 24 hours before that time. Arrival more than 10 minutes late is a no-call/no-show and carries a \$20 fee, as explained in the scheduling policy.

By signing, you acknowledge access to the full HIPAA notice, applicable patient consents, financial and refund policies, laboratory and pharmacy information, portal terms, emergency limits, and relevant treatment documents through PHO's new-patient package page, authorized patient system, or supplied paper copies. You have had the opportunity to ask questions. This registration acknowledges access and your stated choices; it does not automatically sign every separate form, authorize every intervention, complete an optional record release, or enroll you in a recurring payment plan.

By signing, you authorize appropriate care and administration contact using your supplied details, subject to law and documented communication preferences, for scheduling, forms, billing, lab/pharmacy coordination, reminders, and non-urgent follow-up. You have the right to request a reasonable confidential alternative. Ordinary text, email, and voicemail have privacy risks; You will need to send sensitive clinical details through the approved clinical communication method. PHO will safeguard applicable PHI under HIPAA and Florida section 456.057. Care communication does not enroll you in PHO Event & Community SMS Updates or recurring promotions; those choices are separate and optional.

PHO services are cash-pay; an insurance card for independent laboratory use does not mean PHO bills insurance. Clinical eligibility, prescriptions, tests, products, procedures, and results are not guaranteed. More history, records, monitoring, examination, payment, or separate informed consent can be needed. You have the right to decline a proposed treatment or withdraw future consent, and no signature here waives privacy rights, professional standards, or legally required remedies. PHO has no emergency or after-hours emergency clinical service: call 911 or seek emergency care rather than waiting for an appointment, message, or callback.

Patient / representative signature: _____	Date: _____ Time: _____
Printed name: _____	Representative relationship / authority: _____

When you sign electronically, PHO will record the signer, specific document, date, time, and any representative authority.