GETTING STARTED

CLINIC CONSULTANT CONTACT

Your NovaGenix "Consultant" will be your immediate contact for questions, problems or concerns. We recommend storing your Consultant's contact information into your cell phone for future convenience.

- ***Please complete the attached NovaGenix Patient Intake Forms & return them to your Consultant***
- Please note that an in person physical exam is required with our office once a year.

LABS

- NovaGenix staff will accept cash, check or Credit Card payment for lab work.
- Please provide NovaGenix with your blood work, diagnostic procedures or medical records that can better help us care for you.

OFFICE CONSULTATION

Dr. Mackey, a licensed D.O., will see you in his office, where he will conduct a physical exam, talk with you, discuss your past/current medical history and family medical history, and will review your lab test results. Dr. Mackey will then determine the recommended treatment(s) based on clinical and diagnostic evaluation.

Your recommended plan of care will be sent to your Consultant who will contact you to discuss these recommendations.

PRESCRIPTION MEDICATION

- Prescriptions are sent to the pharmacy filled and shipped – most deliveries take 1-2 days.
- <u>You may/will need to sign for the delivery</u>. Please ensure your address is correct. No deliveries to P.O. boxes.
- Some medications need to be REFRIGERATED after delivery – read package instructions carefully.
- You will receive your medication. If you have any questions about how/when to take medication, how to mix medication, how to give yourself an injection – WE CAN HELP! Call your Consultant, as they are here to help you.
- Take your medications as prescribed and follow the physician's recommendations and instructions.
- Report any adverse reactions and monitor your symptoms. What did you feel like before? Is that feeling changing? How do you feel now? Better? Worse? Please let us know.

WE CARE ABOUT YOUR HEALTH

Please continue to see **<u>your primary care physician for continuing medical care</u>**. NovaGenix provides anti-aging and hormone replacement therapies and is NOT Primary Care Practitioner. Our goal is to optimize your health.

If you have any questions, please call your NovaGenix Consultant at 561-277-8260.

<u>Medication Refills</u>: Contact your NovaGenix Consultant two (2) weeks before you need medication refilled to prevent any interruption of treatment.

Please contact us immediately if you have any side effects, problems or concerns.

PATIENT INFORMATION FORM

ALL PATIENTS

Your true and accurate medical history is required for safe assessment and treatment.

PERSONAL INFORMATION

How did you hear about us? ______________________________________ **Today's Date** _______________

Last Name: _________________________________ First Name: _______________________________________

Middle Initial: ________ Male/Female:______________ Date of Birth:___________________________________

Address: ____

City: ___________________________________ State: ________________ Zip Code:______________________

Home Phone: _______________________ Cell Phone:_______________________ Preferred _______________

Do you send and receive text messages?__________

Email address: _______________________________________

Primary Care Doctor ____ Date last seen: ________________________

Physique

Height: _____________ Current weight: _____________ Goal weight: ________________ BMI: ________________

Current Waist/Dress size: ______________ Goal Waist/Dress size:_________ _________

Work History

Retired ☐ Working ☐

Employer information:

Current Occupation:___________________ Employer:_____________________

Are you a civil servant (Police Officer, Fire Fighter, EMT, etc.)? ____

Military Status:_______________________________________

QLS Questions on Life Satisfaction - All Patients copyright Eli Lilly, 2001 European Journal of Endocrinology, QOL in Adult Growth Hormone Deficiency					
How important for you is (are) your	**Not important**	**Somewhat important**	**Important**	**Very important**	**Extremely important**
1. Resilience/ability to tolerate stress					
2. Body shape					
3. Self confidence					
4. Ability to become sexually aroused					
5. Concentration					
6. Physical stamina					
7. Initiative/drive					
8. Ability to cope with your own anger					
9. Ability to tolerate noise and disturbance					
How satisfied are you with your......	**Dissatisfied**	**Somewhat satisfied**	**Satisfied**	**Very Satisfied**	**Extremely Satisfied**
1. Resilience/ability to tolerate stress					
2. Body shape					
3. Self confidence					
4. Ability to become sexually aroused					
5. Concentration					
6. Physical stamina					
7. Initiative/drive					
8. Ability to cope with your own anger					
9. Ability to tolerate noise and disturbance					

Initial and Date___________________________

WOMEN ONLY							
Symptoms…. Review of systems	YES	NO	STABLE?	Symptoms…. Review of systems	YES	NO	STABLE?
CARDIAC				**SKIN**			
Shortness of breath				Loose or thin skin			
Chest pain / pressure				Dry skin / Acne			
Rapid / Irregular heartbeat				Hair growth or loss			
Edema / Swelling				Breast changes / Nipple discharge			
Palpitations				Injection site issues			
Exertional fatigue				Thin nails / Cold Feet / Hands			
GASTROINTESTINAL				**NEUROLOGICAL**			
Weight Loss				Headaches			
Diarrhea / Constipation				Visual changes			
Nausea / Vomiting				Dizziness			
Abdominal pain / Bloating				Trouble walking / Balance disorder			
Blood in stool				Numbness			
Heartburn				Seizures			
MUSCULOSKELETAL				Tremors			
				Generalized Weakness			
Joint pain / Joint swelling				**GENITAL / URINARY**			
Decreased joint mobility				Hematuria (Blood in urine)			
Joint redness				Dysuria (Painful urination)			
Muscle pain				Frequency or Urgency in urination			
Decreased muscle mass / loss				Incomplete emptying / Urinary incontinence			
Muscle weakness / Decreased strength or endurance				Nocturia (Urinating frequently at night)			
Trauma or injury / Poor				Abnormal vaginal bleeding			

SYMPTOM PROGESTERONE	0 NONE	5 SLIGHTLY	10 MODERATE	15 SEVERE	20 EXTREME
Difficulty Concentrating					
Can’t Sleep (Insomnia)					
Depressed / Unhappy					
Anxious					
Headaches					
Moodiness / Emotional swings					
Painful or Swollen Breasts					
Weight gain or bloating					
PMS					
ESTROGEN					
Night Sweats					
Difficulty remembering things					
Hot Flashes					
Vaginal Dryness					
Dry Hair & skin					
Incontinence					
Frequent Urinary Tract Infections					
Inability to reach Orgasm					
Painful Intercourse					
TESTOSTERONE					
Fatigue / Loss of Energy					
Lack of Sexual Desire					

MEN ONLY

Symptoms.... Review of systems	YES	No	STABLE?	Symptoms.... Review of systems	YES	No	STABLE ?
CARDIAC				**MUSCULOSKELETAL**			
Chest pain / pressure				Joint pain			
Rapid irregular heartbeat				Joint redness or swelling			
Edema / Swelling				Decreased joint mobility			
Palpitations				Muscle pain			
Shortness of breath				Muscle weakness / decreased strength or endurance			
Fluid retention				Trauma or injury / Poor muscle recovery after exercise			
SKIN				**NEUROLOGICAL**			
Loose / Thin / Dry skin				Headaches			
Acne				Visual changes			
Hair loss / baldness				Dizziness			
Breast changes				Trouble walking / Balance disorder			
Pain in breast/ Nipple discharge				Numbness			
Injection site issues				Memory problems			
GASTROINTESTINAL				Seizures			
Diarrhea/Constipation				Generalized weakness			
Nausea/Vomiting				Tremors			
Heartburn				Loss of concentration			
Abdominal pain							
Blood in Stool				**PSYCHIATRIC**			
GENITAL / URINARY				Depression			
Hematuria (Blood in urine)				Anxiety / Irritability / Grumpy			
Frequency Urinating				Suicidal / Homicidal ideations			
Dysuria (Painful urinating)							
Urgency to urinate				**ENDOCRINE**			
Incomplete emptying				Heat / cold intolerance			
Urinary incontinence				Abnormal thirst			
Nocturia (Urinating at frequently at night)				Weight gain or loss			
Erectile problems / dysfunction				Change in appetite			
Testicular pain				Fatigue			
Decreased testicular size				Difficulty sleeping			

ADAM Test		
1. Do you have a decrease in libido (sex drive)?	**YES**	**NO**
2. Do you have a lack of energy?	**YES**	**NO**
3. Do you have a decrease in strength and/or endurance?	**YES**	**NO**
4. Have you lost height?	**YES**	**NO**
5. Have you noticed a decreased "enjoyment of life"?	**YES**	**NO**
6. Are you sad and /or grumpy?	**YES**	**NO**
7. Are your erections less strong?	**YES**	**NO**
8. Have you noticed deterioration in your ability to play sports when compared to your prime?	**YES**	**NO**
9. Are you falling asleep after dinner?	**YES**	**NO**
10. Has there been deterioration in your work performance when compared to your prime?	**YES**	**NO**

SOCIAL HISTORY – All Patients	
NUTRITION	
Drink caffeine? Yes☐ No☐	How many cups of coffee or tea a day?
Drink alcohol? Yes☐ No☐	How many drinks per average a day?
Do you smoke? Yes☐ No☐	How many cigarettes/cigars a day?
Do you use drugs? Yes☐ No☐	Type and frequency?
EXERCISE	
Exercise – Strength Training? Days per week	1 3 5 or more days wk? ______
Exercise – Aerobic/Cardio?	1 3 5 or more days wk? ______
LIFESTYLE	
Sleep	< 5 hrs 5-8 hrs 8 hrs
Rate your stress level (10=severe & 1=minimal)	1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY

Please list any relevant past medical history of problems or medical diseases/conditions in your family tree (e.g., Cancer or Heart Disease).

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PAST MEDICAL HISTORY

Please list all diagnosis or past medical conditions and or surgeries.

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Have you ever been on therapy for low testosterone? Describe your symptoms? Please provide your testosterone levels if possible and briefly describe the results of your past treatment.

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Do you have any known allergies to medications? If yes, please describe.

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Medication list: Please list all current medications and doses

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I hereby affirm that the information that I have provided is true and accurate and to the best of my knowledge.

PATIENT SIGNATURE: ____ DATE: ________________

Physician Notes

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Treatment Consent & Waiver ED/PE PATIENTS

Please read this form carefully and completely before signing it

For all ED/PE (erectile dysfunction/premature ejaculation) patients only

I understand that if I get an erection lasting more than four (4) hours I need to seek immediate medical attention. Priapism is an involuntary erection which lasts more than four (4) hours and is unrelieved by ejaculation. This condition is a true urological emergency and early treatment allows the best chance for functional recovery. X__________

It is extremely important to remember never to use Viagra, Cialis, or Levitra before or at the same time as you use Trimix. This is a dangerous combination that can increase the risk of priapism. Be particularly careful with Cialis since it can stay in your blood stream for a longer time. X_________

NEVER take Tri-Mix or any ICP injection within same 24hr period as Viagra/Cialis/Levitra or other ED meds. X_________

IF priapism occurs:

- ✓ Apply ice to perineum/scrotal area- You can use a frozen bag of fruit or vegetables if an ice pack is not available.
- ✓ Walk/jog up and down stairs as this may help redirect blood flow from the penis.
- ✓ Sudafed (pseudoephedrine) is a decongestant available without a prescription but "behind the counter", meaning that you have to ask the pharmacist to get it for you. The pharmacist will ask for your identification since this drug is known to be used in the manufacture of illegal methamphetamine, so the government keeps track of frequent users. Do not use other versions of Sudafed that are available since they do not have pseudoephedrine.
- ✓ Chew on a 30 or 60 mg Sudafed tablet with water if erection has lasted more than 3 hours; effects should start to be noticed within 30 minutes after taking. Take 60mg-150mg orally.
- ✓ Be aware that this drug will disrupt your sleep or may keep you awake for hours. Having sleep aids at hand can help if you are taking Sudafed at nighttime. Benadryl - chew 25mg-50mg orally
- ✓ Note: Do not use Sudafed if you have used an MAO inhibitor such as furazolidone (Furoxone), isocarboxazid (Marplan), phenelzine (Nardil), rasagiline (Azilect), selegiline (Eldepryl, Emsam, Zelapar), or tranylcypromine(Parnate) in the last 14 days.

I understand that there MAY be mild to moderate pain during injection; painful sensation with erection; small amount of bleeding at the injection site. Call immediately if you notice any redness, lumps, swelling, tenderness or curvature of the erect penis. If you experience an erection lasting more than two (2) hours, you may take 2 - 4 pseudoephedrine 30 mg by mouth once and apply an ice pack. If your erection does not go away within the next hour, seek professional help immediately. Erections that last more than six (6) hours can cause severe damage to the penile tissue. I have been consulted by the staff at NovaGenix and completely understand the directions and precautions associated with TriMix or QuadMix as well as tadalafil or sildenafil. X__________

By signing below, I confirm that I have read and been consulted by the medical team from NovaGenix and thoroughly understand the directions, potential risks and precautions that I need to take when administering these medications.

Patient Name and Date (print and signature)____

NovaGenix Medical Staff Name and Date (print and signature)________________________________

Treatment Consent & Waiver ALL Patients

I have been explained to, and understand in their entirety all possible side effects of possible treatments involving Hormone Replacement Therapy (HRT), including but not limited to: Human Chorionic Gonadotropin (HCG), Human Growth Hormone (HGH), Testosterone, Estrogen, Nandralone, Stanozolol, etc. I have been also explained to, and understand in their entirety all possible side effects of Weight Loss Programs, which may include but not be limited to phentermine and vitamins D and B12, as well as Erectile Dysfunction medications, sildenafil citrate, tadalafil, tri-mix, quadmix or Platelet Rich Plasma therapy, Stem Cell treatments and any other treatments/medication that may be discussed with the doctor.

I specifically hold harmless and waive any and all claims or defenses against NovaGenix, LLC and its employees, agents, contractors, contracting physicians, officers, directors, shareholders and contracting medical laboratories for any harm or injury I may sustain resulting from any act or omission of said treating medical doctor or other party.

I also hold harmless and waive any and all claims and defenses against NovaGenix, LLC and its employees, agents, contractors, contracting physicians, officers, directors, shareholders for any harm or possible injury I sustain as a result of my failure to comply with the method of treatment and dosage schedule prescribed by said doctor.

I agree to immediately cease any medical treatment prescribed by said doctor in the event of any adverse response or side effects arising from the prescribed treatment, and provide immediate written notice to NovaGenix, LLC.

I further agree to comply with prescribing instructions for use of all medications.

I, the undersigned patient, understand that the practice of medicine is not an exact science and that the diagnosis and treatment of my condition may involve certain risks or the possibility of injury. I acknowledge that no promises, assurances, or guarantees have been made to me as to the result of diagnostic testing, analysis of test results, examination and medical history, or prescribed treatment protocols by NovaGenix, LLC or its contracting physicians.

I understand that the hormone blood level objective sought to result from my hormone replacement therapy, as prescribed by my treating medical doctor may be the highest level of a standard reference range for my sex, age, or even a higher hormone blood level normally found in a person younger than myself. I understand that hormone replacement therapy for the purpose of elevating my hormone levels to the highest level of standard reference range for my age and sex, or above such range to the level of a younger person, is experimental and may not render any benefits, but may result in unknown adverse results. I have been made aware of the nature, risk, possible alternatives or treatments, possible consequences, and possible complications involved in my treatment.

I understand that recombinant Human Growth Hormone replacement for adults involves the use of a medical drug approved for one purpose for a new and different purpose in an effort to obtain a sought objective of medical treatment. Nevertheless, I consent to care and treatment and I execute this form with complete informed understanding and for the purpose of authorizing NovaGenix, LLC and its physicians to administer to me for the relief of my body ailments, and to enhance my physical condition and health. I understand that the methods of medical treatment offered or provided are not accompanied by any claims, guarantees, or promises.

I understand that Human Chorionic Gonadotropin (HCG), involves the use of a medical drug approved for one purpose for a new and different purpose in an effort to obtain a sought objective of medical treatment. Nevertheless, I consent to care and treatment and I execute this form with complete informed understanding and for the purpose of authorizing

NovaGenix, LLC and its contracting physicians to administer such treatments. I understand that the methods of any of NovaGenix, LLC medical treatments offered or provided, including Stem cell, PRP, hormone therapy, ED treatments and Weight loss services are not accompanied by any claims, guarantees, or promises and that all sales are final.

I agree to present my photo identification at any time my blood is drawn pursuant to NovaGenix, LLC test requisitions.

I understand that there are no refunds for prescription medications as per State and Federal Law. I also understand the medicine dispensed to me is for my personal use only and I will not sell or share my prescribed medicine with others.

I understand that medical information revealed by me may be used for continued medical research purposes, but that I will not be personally identified at any time.

I understand that a prescribed drug ordered for me from NovaGenix, LLC may be dispensed directly to me by a pharmacy in my country.

Consent for Medical Treatment (BHRT, PRP, Stem Cell Therapy, ED/PE, Weight Loss)

I, ____, understand that I have a condition that requires medical treatment.

I authorize NovaGenix, LLC and its physicians to determine what kind of treatment is to be given and to perform such procedures as he/she may deem necessary, in his/her professional judgment, in an effort to preserve my health.

Additionally, I authorize the personnel of NovaGenix, LLC to administer the therapy which my doctor may order. I fully understand that the medical tests or treatments may involve certain unavoidable risks, which have been fully explained to me.

I understand that the practice of medicine and surgery are not exact sciences and acknowledge that no guarantee or assurance has been made to me as to the results of treatment or examinations.

Cancellation of services policy: All Sales are final, as we cannot accept prescription medications after they have been prescribed, or refund for procedures after they have been performed. Patients may cancel recurring monthly services at any time with ***30 Day's notice*** (email or phone call will suffice).

Future Lab Work NovaGenix, LLC will provide future blood/lab work for recurring monthly patients after they start treatment at 8-10 weeks and once again in 12 months after starting therapy. If patients would like additional tests, it may be at an additional cost to the patient.

I certify that I have read this form in its entirety and have had it explained to me upon request, and I certify that I fully understand its contents in their entirety.

SIGNATURE OF PATIENT: ____ **DATE:** _________________________

NOTICE OF PRIVACY POLICIES ALL PATIENTS

[UPDATED JANUARY 1, 2019]

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION:

Each time you visit the physician, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and plan for future care or treatment. This information is referred to as your medical record and serves as a:

- Basis for planning your care and treatment.
- Means of communicating among the many health professionals who contribute to your care.
- Legal documentation describing the care you receive.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research.
- A source of information for public health officials who improve the health of the State and nation.
- A source of data for our planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we receive.

USES AND DISCLOSURES:

- **Treatment—**Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating health, diagnosing medical conditions and providing treatment.
- **Payment**—Your health information may be used to seek payment from your health plan, automobile insurer, worker's compensation, or from credit card companies that you may use to pay for services. For example: date of service, services provided, and medical condition being treated.
- **Health Care Operations**—Your information may be used as necessary to support the day to day activities and management of NovaGenix, LLC, for budget and financial reporting and activities to evaluate and promote quality.
- **Law Enforcement—**Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.
- **Public Health Reporting—**Your health information may be disclosed to public health agencies as required by law. (Reporting certain communicable diseases to public health department.)
- **Communication with family—**Health professionals using their best judgment, unless otherwise requested, 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.
- **Additional uses of information—**Appointment reminders.

YOUR HEALTH INFORMATION RIGHTS:

Although the medical record is the physical property of the practice, the information belongs to you.
You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.524
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.524
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:
We are required to:

- Maintain the privacy of your health information.
- Provide you with this notice of practices.
- Abide by the privacy policies and practices outlined in this notice.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will have the information available for you to request at our office. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:
If you have questions and would like additional information, you may contact the practice's Privacy Officer at:

NovaGenix, LLC
609 N. Hepburn Ave Suite 106
Jupiter, Fl 33458
561-277-8260

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for the filing of a complaint with either the Privacy Officer or the Office of Civil Rights.

PATIENT SIGNATURE: ____ DATE: _________________

NOVAGENIX MISSION STATEMENT

Our GOAL is simple…To improve every aspect of your life by first achieving optimal health.

We practice the highest standard of evidence-based medicine while being grounded in common sense and open minded thinking.

NovaGenix is a Doctor driven, Doctor directed company designed for one purpose…… Optimal Health!

Medical Treatment Policy

Patient is aware that our primary objective and focus is on prevention and wellness.

- All therapy administered by NovaGenix, LLC is for maintenance of health and wellness, not performance enhancement.
- NovaGenix, LLC provides anti-aging and hormone replacement therapies and works with primary care providers to help patients receive well rounded care; NovaGenix, LLC does not provide primary care.
- NovaGenix, LLC has no intention now or in the future to use hormone replacement for performance enhancement, or improvement in physical strength, muscle size etc.
    - We are aware that hormone replacement therapy can be used for enhancing athletic performance; however, the doses we prescribe are for replacement only. (Ex: Growth Hormone has been used for performance enhancement in athletics @ 4-5 iu daily; Replacement doses are 2 iu Mon – Fri, weekends off.)
- We follow clinical signs and symptoms as our main source of diagnosis. Lab values are another useful tool but are not the full picture of your health and cannot replace clinical evaluation. Laboratory ranges on hormone values are based on the average population. However, as much as 20% (or 1 in 5 individuals) will not be at optimal health within that range and may require higher levels to achieve exceptional health.
- While individual results may differ, hormone replacement therapy has shown in countless peer reviewed journals and scientific studies to reduce and prevent the leading medical problems that cause diseases which afflicts over 50% of all Americans.
- As a member of the NovaGenix, LLC team– our philosophy is to aggressively focus on preventive medicine using vitamins, supplements and hormone replacement to improve overall quality of life and vitality.

I have read and understand the policy: ___________________________________ _________________

Signature Date

AUTHORIZATION
FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize NOVAGENIX, LLC to disclose the information described below to:

____

[add here the name or other specific identification of the person(s) or type of persons or entity to whom NovaGenix, LLC *may make the requested use or disclosure]*

NovaGenix, LLC is authorized to furnish copies of any and all medical records it may have concerning myself with respect to any injury or illness, medical history, consultations, prescriptions, treatment, or hospital records, including, but not limited to, x-ray studies, MRI studies, diagnostic procedures, or other medical records. If these records include information relating to any HIV testing for the AIDS antibody, Sexually Transmitted Diseases (STD's), drug or alcohol use/abuse and treatment, or psychiatric/psychological evaluations and treatment, I hereby specifically authorize their release.

This authorization expires one year from the date written below the signature unless a different expiration date or expiration event is written here: ___________________________________.

Except to the extent that NovaGenix, LLC has taken action in reliance on this Authorization, you have the right to revoke this Authorization by giving written notice addressed to NovaGenix, LLC Privacy Officer. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA final privacy rule.

_______________________________________ _________________________

Patient name (please print) Patient's Date of Birth

_______________________________________ _________________________

Patient's Signature Date Signed

____

Witness' Signature

If this authorization is signed by a personal representative of the patient please describe the personal representative's authority to act for the patient:_______________________________

NOVAGENIX, LLC AUTOMATIC CREDIT CARD AUTHORIZATION FORM

In an effort to better serve you and simplify your billing experience, NovaGenix, LLC requires credit card preauthorization for recurring monthly charges. Charge card information is filed with your confidential information and kept secure. Accounts on file will be charged automatically each month upon the due date. We appreciate your prompt payment.

Name: ____

Billing Address: ____

____

____

Telephone: ____

E-mail Address :____

Type of Card: ☐Visa ☐ Mastercard ☐American Express

Credit Card Number: ____

Exp. Date: ______________________ Security Code:______________________

___________ (initial) I hereby authorize NovaGenix, LLC. to automatically charge my account each month all fees due. I understand that my card will be charged on a monthly basis. I understand I may cancel recurring monthly services at any time with ***30 Day's notice*** (email or phone call will suffice).

PERSONAL GUARANTEE: I hereby irrevocably and unconditionally guarantee to NovaGenix, LLC the timely payment and performance of all of my liabilities and obligations pursuant to this agreement. Should I fail to pay charges when due, then after notice by NovaGenix, LLC, I shall immediately cure my nonpayment in the same manner and as completely as I am obligated to do. My liability is direct, immediate, absolute, continuing, unconditional and unlimited. NovaGenix, LLC shall not be required to pursue any remedies it may have against me as a condition to enforcement of this Guaranty, nor shall it be discharged or released by reason of the discharge or release of me for any reasons, including a discharge in bankruptcy, receivership or other proceedings.

Card Holder Name: ____

Signature of Card Holder Date:__________________________________

If, after a payment by credit card, you later dispute the charges, unless prohibited by law, you agree not to cancel, revoke, charge back, or dispute any previously entered charge on your credit card. If you do so, and it is later determined that the charge was properly authorized, you agree to pay all out of pocket fees and costs incurred by NovaGenix, LLC as a result of the improper cancellation, revocation, charge back, or dispute.

Physical Examination

Patient Name____ **Date:**______________
DOB_____________

B/P:_____ **HR:**_____ **RR:**_____ **Height:**_____ **BMI:**_____ **Weight:**_____

HEENT: □Normal □Abnormal ____

Neck: □Normal □Abnormal ____

Lymph Nodes: □Normal □Abnormal____

Heart: □Normal □Abnormal____

Breasts: □Normal □Abnormal____

Lungs: □Normal □Abnormal____

Abdomen: □Normal □Abnormal____

GU: □Normal □Abnormal ____

Prostate: □Normal □Abnormal ____

□Deferred to next visit □Deferred to PCP ____

Peripheral Vascular: □Normal □Abnormal____

Musculoskeletal: □Normal □Abnormal____

Spine: □Normal □Abnormal____

Skin: □Normal □Abnormal____

Neurological: □Normal □Abnormal____

Mental: □Normal □Abnormal____

Summary of physical findings:

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Examining Physician Signature______________________________

Medical Director: Dr. Timothy Mackey

DATE	PROGRESS NOTES: