FLORIDA CENTER FOR HORMONES & WELLNESS

Medicare Private Contract for Services from Physician who has Opted Out

This Private Contract is entered into by and between:
Patient Name or Legal Representative: _____
(each one referred to herein as "Patient") and **John Christy Carrozzella, MD** ("Doctor") pursuant to the Medicare requirements that relate to physicians who have opted out of Medicare. Doctor has filed the required Affidavit with Medicare within the time period required for this Private Contract to be effective.

1. Doctor's Obligations. Doctor hereby informs Patient of the following and agrees to undertake the following actions:

a. Doctor has not been excluded from participation in Medicare under §§1128, 1156 or 1892 of the Social Security Act. The decision to opt out of Medicare was a strictly voluntary one.

b. Doctor will make a copy of this Private Contract available to CMS upon its request.

c. The expected or actual effective date and the expiration date of the opt-out period to which this Private Contract applies are indefinite unless otherwise notified.

d. Doctor and Patient must enter into a new Private Contract for each opt-out period.

e. Doctor will provide a photocopy of this Private Contract to Patient or to Patient's legal representative before items or services are furnished to Patient under the terms of this Private contract.

f. Doctor will retain an original of this Private Contract with original signatures of both parties, for the duration of the opt-out period, although a scanned copy shall carry the same weight as the original.

2. Patient's Obligations. The Patient or the Patient's legal representative agrees to the following:

a. Patient accepts full responsibility for payment of Doctor's charge for all services furnished by Doctor.

b. Patient understands that Medicare limits do not apply to what Doctor may charge for items or services furnished to Patient by Doctor.

c. Patient agrees not to submit a claim to Medicare or to ask Doctor to submit a claim to Medicare.

d. Patient understands that Medicare payment will not be made for any items or services furnished by Doctor that would have otherwise been covered by Medicare if there was no Private Contract and a proper Medicare claim had been submitted.

e. Patient has entered into this Private Contract with the knowledge that Patient has the right to obtain Medicare-covered items and services from a physician who has not opted out of Medicare, and that Patient is not compelled to enter into Private Contracts that apply to other Medicare-covered services furnished by other physicians who have not opted out.

f. Patient understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

g. Patient entered into this Private Contract at a time when Patient did not require any emergency or urgent care services.

3. Controlling Law. The terms of this Private Contract shall be interpreted and controlled by applicable Medicare regulations, as amended from time to time. Both parties agree to comply with all such Medicare regulations and enter into such agreements as may be required from time to time by such regulations.

4. Patient Representative. If this Private Contract is being signed by a Patient Representative on Patient's behalf, the Patient Representative will provided Doctor with the documentation required to demonstrate that Patient Representative has the requisite legal authority to sign this Private Contract on Patient's behalf.

The parties have read and understood the provisions of this Private Contract and enter into this agreement freely and voluntarily.

Doctor:

_____

John Christy Carrozzella, MD

Date:

Patient/Patient Representative:

_____

Name:

Relationship to Patient:

Date:

An electronic copy of this document shall carry the same weight as an original.

FLORIDA CENTER FOR HORMONES & WELLNESS

MALE INTAKE ASSESSMENT

First/Last Name _____

Date of Birth _____/_____/_____

Address _____

City/State_____Zip Code_____

Phone: Home (___)_____Work (____)_____Cell (____)_____

Which phone number may we use to leave messages? O Home O Work O Cell O None

E-mail _____

Your Occupation_____Hours per week _____

Your Employer _____

Significant Other _____

Significant Other Occupation_____

Emergency Contact _____

Primary Care Physician_____Phone _____

Do you want us to send your notes to your PCP? O Yes O No

Insurance Provider _____

How did you hear about Florida Center for Hormones and Wellness? _____

Medical Information

Please bring copies of current (within past 2 years) medical reports and laboratory tests to your appointment.

_____

_____

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Dr. John C. Carrozzella, M.D. Florida Center for Hormones & Wellness
7513 West Sand Lake Rd, Orlando, Florida 32819
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR HORMONES & WELLNESS

Date of Last Primary Care Visit: _____ Result: _____

Date of last Digital Rectal Exam (DRE) for the Prostate: _____

Normal? YES NO

If not normal, please explain: _____

_____

Date of last Prostate Specific Antigen (PSA) blood test: _____ I do not know

Are you sexually active? YES NO Comments: _____

Are there any specific questions regarding your sex life or intimacy that you would like to discuss?

_____

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Doctor Notes: _____

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FLORIDA CENTER FOR HORMONES & WELLNESS

List the top three reasons why you are here today for your consultation (Please answer. This Question is very important)

1. _____

2. _____

3. _____

Please describe and other health concerns you might have; and also discuss and weight concerns you might have
PRINT AS MANY OF THIS PAGE NECESSARY

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HORMONES & WELLNESS

MEDICATIONS: List prescription and over-the-counter drugs you are currently taking or have previously taken for extended periods of time (greater than a month). Please bring your medications to your appointment.

Drugs Name	Reason for Taking	Dose (mg/day)	Date Started	Date Discontinued	Side Effects

Please list allergies to medications: _____

_____

_____

_____

Nutritional Supplements - Examples: Vitamin, minerals, herbal & Homeopathic remedies

For evaluation of content and quality please bring supplements to your appointment

Name /Type	Reason for Taking	Dose	Date Started	Results/Benefits

_____

_____

_____

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Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
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FLORIDA CENTER FOR HORMONES & WELLNESS

Hospitalization, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure/Admission	Outcome/Results

Family History – Use the key below to identify family members and their associated health conditions. Please list type where parentheses are present.

M: Mother F: Father S: Sister B: Brother G: Grandparents A: Aunt U: Uncle C: Child

Condition	Relative	Condition	Relative
Allergies		Eczema	
Alcoholism		Epilepsy	
Anemia		Gout	
Alzheimer's		Heart Disease	
Arthritis (Rheumatoid)		High Blood Pressure	
Arthritis (Osteo)		High Cholesterol	
Asthma		Kidney Disease	
Bleeding Disorder		Lupus	
Cancer ( )		Mental Disorder	
Cancer ( )		Nervous System Disease	
Celiac Disease		Obesity	
Cohn's Disease		Stroke	
Colitis		Thyroid (Hypo/Hyper)	
Depression		Other ( )	
Diabetes Type 1		Other ( )	
Diabetes Type 2		Other ( )	

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Personal Habits – Substance Use

	Tobacco	Alcohol	Caffeine	Drugs
Currently Use				
Previously Used				
Never Used				
How much/many per day/week/month				
Specify Type: (cigarettes/cigars/ pipe/chewing tobacco; beer/wine/ spirits; tea/coffee/espresso/soft drinks/ energy drinks/ weight loss products; cocaine/marijuana/ heroin/ ecstasy)				
Duration of use (month/years)				
Date Quit				

Exercise (Complete this section only if you exercise regularly)

Type of exercise (biking, walking, yoga, jogging, weights, swimming)	**How long per session** (minutes, hours)	**Frequency** (daily, weekly)	**How long have you been doing this specificactivity** (week, month, years)

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Male Hormone Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

	Symptoms	Not at all	A Little	Some	Quite a bit	Extreme
1	**Decline in your feeling of general well-being** (general state of health, subjective feeling)					
2	**Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)					
3	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes without strain)					
4	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)					
5	**Increased need for sleep, often feeling tired**					
6	**Irritability** (feeling aggressive, easily upset about little things, moody)					
7	**Nervousness** (inner tension, restlessness, feeling fidgety)					
8	**Anxiety** (feeling panicky)					
9	**Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)					
10	**Decrease in muscular strength** (feeling of weakness)					
11	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)					
12	**Feeling that you have passed your peak**					
13	**Feeling burnt out, having hit rock-bottom**					
14	**Decrease in beard growth**					
15	**Decrease in ability/frequency to perform sexually**					
16	**Difficult to climax sexually**					
17	**Decrease in the number of morning erections**					
18	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)					
19	**Weight Gain and unable to lose**					
20	**Not getting the results that you would like in the gym**					
	Row Total					
	OVERALL TOTAL					

Name: _____

Date: _____

Thyroid Hormone Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

	Thyroid Symptoms	Not at all	A Little	Some	Quite a bit	Extreme
1	**Weight gain**					
2	**Chronic constipation**					
3	**Feeling cold (especially hands and feet) even on warm days**					
4	**Fatigue, exhaustion and low energy throughout the day**					
5	**Slowness of thought processes (brain fog)**					
6	**Indecisiveness**					
7	**Poor memory and concentration**					
8	**Sluggishness**					
9	**Muscle weakness**					
10	**Pain and stiffness in muscles or joints**					
11	**Depression, mood swings and severe PMS**					
12	**Thick, dry, coarse skin**					
13	**Creviced, cracking skin on heels, elbows and knee caps**					
14	**High cholesterol**					
15	**Menstrual cycle irregularities (prolonged and heavy)**					
16	**Infertility**					
17	**Numbness and tingling (especially in hands and face)**					
18	**Brittle hair and nails**					
19	**Hair loss**					
20	**Headaches or migraines**					
21	**Low Blood pressure problems**					
22	**Reduced libido**					
23	**Stiff neck and shoulders**					
23	**Eye brow thinning (outer third)**					
24	**Irritability**					
25	**Fluid Retention**					
	Hypo-thyroid row total					
	HYPO-THYROID TOTAL					
	Hyper-Thyroid Symptoms					
1	**Heart palpitatons / High heart rate** (do you feel your heart beeting out of your chest)					
2	**Irritability / Restlessness**					
3	**Tremors / Shakiness**					
4	**Anxiety**					
5	**Diarrhea**					
6	**Feeling of being overheated / Excessive sweatiness**					
7	**Can't sleep / Insomnia**					
8	**Itching and hives**					
9	**Mental and emotional disturbances**					
10	**Hair Loss**					
	Hyper-thyroid row total					
	HYPER-THYROID TOTAL					

Name: _____

Date: _____

Cardiovascular Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

1	**Gender**	Female	Male
2	**Race**		
3	**Do you have a known heart condition?**	YES	NO
4	**Are you overweight?**	YES	NO
5	**Do you exercise regularly?**	YES	NO
6	**Do you smoke?**	YES	NO
	Did you ever smoke?	YES	NO
7	**If yes, how many packs a day?**		ppd
8	**If yes, how long ago did you quit?**		
9	**Are you being treated for or do you have High Blood Pressure?**	YES	NO
10	**Do you have a sugar metabolism problem, insulin resistance, metabolic syndrome or diabetes?**	YES	NO
11	**Do you have a high cholesterol problem?**	YES	NO
12	**If yes, what is your untreated Total Cholesterol?**		mg/dl
13	**If yes, what is your untreated Total Cholesterol?**		mg/dl
14	**If yes, do you take a statin for cholesterol?**	YES	NO
15	**Family History of Heart Attack?**	YES	NO
16	**Family History of Angina (chest pain with exertion)?**	YES	NO
17	**Family History of Stroke?**	YES	NO
18	**Family History of Diabetes?**	YES	NO

Doctor Notes:

Name: _____

Date: _____

International Index of Erectile Dysfunction Questionnaire (15Q-LF)

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

These questions ask about the effects that your erection problems have had on your sex life over the last four weeks. Please try to answer the questions as honestly and as clearly as you are able. Your answers will help your doctor to choose the most effective treatment suited to your condition. In answering the questions, the following definitions apply:

sexual activity includes intercourse, caressing, foreplay & masturbation

sexual intercourse is defined as sexual penetration of your partner

sexual stimulation includes situation such as foreplay, erotic pictures etc.

ejaculation is the ejection of semen from the penis (or the feeling of this)

orgasm is the fulfilment or climax following sexual stimulation or intercourse

1	**How often were you able to get an erection during sexual activity?**	0 - No sexual activity 1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box
2	**When you had erections with sexual stimulation, how often were your erections hard enough for penetration?**	0 No sexual activity 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
3	**When you attempted intercourse, how often were you able to penetrate (enter) your partner?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
4	**During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
5	**During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?**	0 Did not attempt intercourse 1 Extremely difficult 2 Very difficult 3 Difficult 4 Slightly difficult 5 Not difficult	Answer in this Box

Name: _____

Date: _____

International Index of Erectile Dysfunction Questionnaire (15Q-LF)

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

6	**How many times have you attempted sexual intercourse?**	0 No attempts 1 One to two attempts 2 Three to four attempts 3 Five to six attempts 4 Seven to ten attempts 5 Eleven or more attempts	Answer in this Box
7	**When you attempted sexual intercourse, how often was it satisfactory for you?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
8	**How much have you enjoyed sexual intercourse?**	0 No intercourse 1 No enjoyment at all 2 Not very enjoyable 3 Fairly enjoyable 4 Highly enjoyable 5 Very highly enjoyable	Answer in this Box
9	**When you had sexual stimulation or intercourse, how often did you ejaculate?**	0 No sexual stimulation or intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
10	**When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?**	1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
11	**How often have you felt sexual desire?**	1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always	Answer in this Box
12	**How would you rate your level of sexual desire?**	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high	Answer in this Box
13	**How satisfied have you been with your overall sex life?**	1 Very dissatisfied 2 Moderately dissatisfied	Answer in this Box

Name: _____

Date: _____

International Index of Erectile Dysfunction Questionnaire (15Q-LF)

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

3 Equally satisfied & dissatisfied
4 Moderately satisfied
5 Very satisfied

14	**How satisfied have you been with your sexual relationship with your partner?**	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied	Answer in this Box

15	**How do you rate your confidence that you could get and keep an erection?**	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high	Answer in this Box

		Max Score
Erectile Function (1, 2, 3, 4, 5, 15)		30
Orgasmic Function (9, 10)		10
Sexual Desire (11, 12)		10
Intercourse Satisfaction (6, 7, 8)		15
Overall Satisfaction (13, 14)		10
TOTAL		75

Name: _____

Date: _____