PREMIER
TOTAL HEALTHCARE

NEW PATIENT INFORMATION

1. PATIENT INFORMATION

Full Name _____ Date of Birth _____ Age ____ Gender: ☐ Male ☐ Female ☐ Other

Address _____ Apt ____ City _____ State ___ Zip _____

Phone _____ Email _____ Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____ Height _____ Weight _____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Other | Occupation _____

Active Military Member: ☐ Yes ☐ No | Retired Military Member ☐ Yes ☐ No

Emergency Contact _____ Relationship _____ Phone _____

Permission to disclose information to people involved in my healthcare:

Name _____ Relationship _____

Name _____ Relationship _____

How did you hear about us or who referred you? _____

Primary Care Physician _____ Phone _____

Cardiologist _____ Phone _____

Specialist _____ Phone _____

☐ I would like to receive appointment reminders and marketing discounts/promotions texts ☐ I would like to opt-out

Reason for visit: *The more descriptive the better we can assist you*

_____

_____

_____

2. MEDICAL HISTORY

Have you had Corona Virus? ☐ Yes ☐ No Have you been Vaccinated for the Corona Virus? ☐ Yes ☐ No

Have you had a Booster for the Corona Virus? ☐ Yes ☐ No Do you suffer from Long-Covid? ☐ Yes ☐ No

Do you have a family history of any medical problems? ☐ Yes ☐ No

If yes, explain _____

SURGICAL HISTORY(please list all surgeries with dates) ☐ Never had surgery

Type _____ Date _____ Type _____ Date _____

Type _____ Date _____ Type _____ Date _____

Please list **ALL** allergies and describe reactions: ☐ Do not have allergies

_____

Please list ALL CURRENT Medications and/or Dietary Supplements including:

(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins, and Herbal Supplements)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Continued on next page...

Do you use Aspirin or NSAIDs drugs? ☐ Yes ☐ No If Yes, brand name _____

Are you on Blood Thinners? ☐ Yes ☐ No If Yes, Medication name _____

Have you used Diet Pills in last 2 weeks? ☐ Yes ☐ No If Yes, brand name _____

Have you taken Steroids/Hormones within 1 year? ☐ Yes ☐ No If Yes, brand name _____

Do you smoke Tobacco/Vape/Hookah ☐ Yes ☐ No If Yes, #____ packs per day # ____ of years ☐ Quit, when _____

Do you use recreational drugs ☐ Yes ☐ No If Yes, type _____ Usage: ☐ Often ☐ Occasional

Do you drink alcohol ☐ Yes ☐ No If Yes, ☐ Daily ☐ 2-3X Week ☐ Weekends Only ☐ Socially ☐ In Recovery

Are you currently pregnant? ☐ Yes ☐ No If Yes, how many months _____ Are you breastfeeding ☐ Yes ☐ No

Have you ever been hospitalized for a medical condition other than surgery? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever experienced a serious reaction to anesthesia, medical injections, or medical procedures? ☐ Yes ☐ No

If yes, please explain: _____

Do you have implanted medical hardware; joint replacements, surgical plates, screws, or spinal implants? ☐ Yes ☐ No

If yes, please specify: _____

Have you ever experienced any major injuries, broken bones, concussions, or serious falls? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently receiving treatment from another physician or medical specialist? ☐ Yes ☐ No

If yes, for what condition? _____

Do you currently experience numbness, tingling, muscle weakness, balance problems, or frequent falls? ☐ Yes ☐ No

If yes, please explain: _____

Do you have physical limitations that interfere with; walking, exercising, working, or daily activities? ☐ Yes ☐ No

If yes, please explain: _____

Have you experienced any unexplained weight gain or weight loss within the past 6 months? ☐ Yes ☐ No

If yes, please explain: _____

Do you exercise or participate in physical activities regularly? ☐ Yes ☐ No If yes, how many days per week? _____

How many hours of sleep do you typically get per night? _____

Pharmacy Name _____ **Pharmacy Phone** _____

Patient Full Name _____ Date _____

Patient Signature _____

TYPE YOUR NAME IN THE SIGNATURE LINE

*If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.

MEDICAL HISTORY

Patient Full Name _____ Date _____

PLEASE SELECT ONLY THE ONES THAT APPLY BY CHECKING "YES" NEXT TO EACH CONDITION THAT APPLIES TO YOU

CARDIOVASCULAR		**NEUROLOGICAL**	
High Blood Pressure	☐ Yes	Stroke	☐ Yes
Heart Attack	☐ Yes	Seizures	☐ Yes
Angina / Chest Pain	☐ Yes	Fainting	☐ Yes
Heart Bypass Surgery	☐ Yes	Dizziness	☐ Yes
Stents	☐ Yes	Headaches/Migraines	☐ Yes
Pacemaker	☐ Yes	**CHRONIC PAIN**	
Defibrillator	☐ Yes	Sciatica	☐ Yes
Heart Failure	☐ Yes	Herniated Discs	☐ Yes
Irregular Heartbeat	☐ Yes	Neuropathy	☐ Yes
Heart Murmur	☐ Yes	Lower Back Pain	☐ Yes
ENDOCRINE		Neck Pain	☐ Yes
Hormone Imbalance	☐ Yes	Difficulty Moving Neck / Head	☐ Yes
Diabetes - Type 1	☐ Yes	Uses Cane / Walker to Ambulate	☐ Yes
Diabetes - Type 2	☐ Yes	**GASTROINTESTINAL**	
Hypothyroidism	☐ Yes	Gallstones	☐ Yes
Hyperthyroidism	☐ Yes	Liver Condition	☐ Yes
Hypoglycemia	☐ Yes	Kidney Condition	☐ Yes
High Cholesterol	☐ Yes	Ulcers	☐ Yes
RESPIRATORY		Hernias	☐ Yes
Asthma	☐ Yes	Heartburn	☐ Yes
Bronchitis	☐ Yes	Reflux	☐ Yes
Emphysema	☐ Yes	Irritable Bowel Syndrome	☐ Yes
COPD	☐ Yes	**SKIN**	
Shortness of Breath	☐ Yes	Skin Cancer - Where: _____	☐ Yes
Cough	☐ Yes	Radiation	☐ Yes
Cough with Sputum	☐ Yes	Scleroderma	☐ Yes
Sleep Apnea	☐ Yes	Psoriasis	☐ Yes
CPAP Machine at Night	☐ Yes	Eczema	☐ Yes
PSYCHIATRIC		**HEMATOLOGY**	
Depression	☐ Yes	Anemia	☐ Yes
Anxiety	☐ Yes	Clotting Disorder	☐ Yes
Psychiatric Care	☐ Yes	Sickle Cell	☐ Yes
Obsessive Compulsive Disorder	☐ Yes	Blood Clots	☐ Yes
Bipolar Disorder	☐ Yes	Bruises Easily	☐ Yes
Schizophrenia	☐ Yes	**OTHER**	
AUTOIMMUNE		Other Cancer - Where: _____	☐ Yes
Lupus	☐ Yes	Cold Sores	☐ Yes
Lyme Disease	☐ Yes	HIV / AIDS	☐ Yes
Multiple Sclerosis	☐ Yes	Hepatitis - Type: _____	☐ Yes
Vasculitis	☐ Yes	Hearing Loss	☐ Yes
Rheumatoid Arthritis	☐ Yes	Memory Loss	☐ Yes
Celiac Disease	☐ Yes		
Hashimoto's Disease	☐ Yes		

Please list any other medical conditions that are NOT listed above:

_____

_____

PREMIER
TOTAL HEALTHCARE

MEDICAL CONSENT FORM

Patient Name: _____

I, the undersigned, consent to receive medical evaluation and treatment from Dr. Matthew Popkin, MD, including services related to weight management, hormone therapy, peptide therapy, joint injections, and Botox administration, provided in-office or via telemedicine.

I acknowledge that:

- I will have the opportunity to ask questions about my care, and all questions will be answered.
- Medical treatment may involve risks or complications, and no results are guaranteed.
- Dr. Popkin and/or qualified personnel under his supervision may perform procedures deemed necessary.
- I am responsible for all charges associated with my treatment. No insurance accepted.

SUD & Specially Protected Information (Initial Required)

I authorize the release of the following, if applicable (initial each):

_____ Substance Use Disorder Treatment Records (including drug/alcohol abuse records)

_____ Mental Health Records (excluding psychotherapy notes)

_____ HIV/AIDS Test Results or Treatment

_____ Genetic Test Results

Expiration: This authorization expires when I provide notice of termination.

Substance use disorder records are protected by federal confidentiality rules (42 CFR Part 2).
Disclosure of these records is prohibited unless specifically authorized by the patient or otherwise permitted by law.
Any further disclosure of this information by the recipient may be prohibited.

I have read and understand the above consent and have initialed the SUD disclosure, where applicable. By signing below, I hereby consent to the proposed treatment plan and intend for this consent to apply to the entire course of treatment for my current condition.

_____ _____

Patient Signature Date

TYPE YOUR NAME IN THE SIGNATURE LINE
If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.

HIPAA Notice of Privacy Practices

PREMIER TOTAL HEALTHCARE
2415 HOLLYWOOD BLVD
HOLLYWOOD FL 33020
954.456.0250

Your Information. Your Rights. Our Responsibilities.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations, except SUD records as explained in Feb 15, 2026 addendum, without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Required Addendum to our NPP (Notice of Privacy Practices)

Effective as of February15,2026

PREMIER TOTAL HEALTHCARE
2415 HOLLYWOOD BLVD
HOLLYWOOD FL 33020
954-456-0250

Special Privacy Protections for Certain Health Information

We are **not primarily a substance use disorder (SUD) treatment program. We may receive and maintain SUD-related information incidentally** (e.g., referrals, history, meds, labs) and that information we maintain may be subject to additional federal privacy protections, including records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected by federal law (42 C.F.R. Part 2), which, in some cases, is more restrictive than HIPAA. When these stricter rules apply, we follow them.

How We May Use and Disclose Health Information

We may use and disclose your health information for treatment, payment, and health care operations. When information includes substance use disorder records, additional legal requirements may apply, including your written consent before using or disclosing that information.

Limits on Use of Substance Use Disorder Records

Federal law places **strict limits** on how substance use disorder records may be used or disclosed. Substance use disorder records cannot be used or disclosed to initiate or substantiate civil, criminal, administrative, or legislative proceedings without written consent or a qualifying court order.

Authorization and Consent

Certain uses and disclosures require written authorization. You may revoke authorization at any time by written request, except where already relied upon. If your health information includes substance use disorder records, your authorization may allow us to use and disclose that information for treatment, payment, and health care operations, as permitted by law.

Your Rights Regarding Your Health Information

You have rights to inspect, access, amend, request restrictions, request confidential communications, and receive an accounting of disclosures, as permitted by law.

Redisclosure Notice

If your health information is disclosed to another party, that party may be permitted to **redisclose** the information, and it may no longer be protected by HIPAA. However, **substance use disorder records** may continue to be protected by federal law even after disclosure, depending on the circumstances.

Public Health and De-Identified Information

We may disclose **de-identified health information** for public health, research, or health care operations purposes as permitted by law. De-identified information does not identify you and cannot reasonably be used to identify you.

Fundraising Communications

We may contact you for **fundraising purposes**. You have the right to **opt out** of receiving fundraising communications at any time. Your decision to opt out will **not affect your access to care**.

Complaints and Enforcement

If you believe your privacy rights have been violated, you may file a complaint with us or with the **U.S. Department of Health and Human Services**. You will not be retaliated against for filing a complaint.

Changes to This Notice

We reserve the right to change this Notice of Privacy Practices at any time. Any changes will apply to all health information we maintain. The current version of this Notice will be available upon request and on our website.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You have the right to Choose someone to act for you: - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Provided By HCSI

PT Signature **Date**

TYPE YOUR NAME IN THE SIGNATURE LINE

If you are filling out this form online, typing your full name in the signature line indicates your agreement to the terms and conditions. If left blank, you may sign the form in person at Premier on the day of your appointment.