PREMIER
TOTAL HEALTHCARE

NEW PATIENT WEIGHT LOSS QUESTIONNAIRE

Patient Information

Full Name:			Date:	
Street Address:				
City:		State:		Zip:
Home Phone:		Cell Phone:		
Email Address:				
Sex: ☐ M ☐ F ☐ Other	Birth date:	Age:	Height:	Weight:
Race (ie. White, Asian, African American):			Hispanic or Latino:	☐ Yes ☐ No
Marital Status: ☐ Single	☐ Married	☐ Widowed	☐ Separated	☐ Divorced
Occupation:				
How did you hear about us?				
Primary Care Physician:			Phone:	
Emergency Contact:		Phone:		Relationship:

Health and Wellness History

Has your doctor advised you to lose weight?	☐ Yes	☐ No
Do you have any dietary restrictions? Please explain:	☐ Yes	☐ No
How often do you exercise?	What type of exercise?	
Do you feel stressed? Please explain:	☐ Yes	☐ No
Check ALL that apply to you: ☐ Pregnant ☐ Breast Feeding ☐ Currently Undergoing Chemotherapy		
Do you drink Alcohol: ☐ Yes ☐ No If so, How much: _____ Day / Week	Do you Smoke or Vape: ☐ Yes ☐ No If so, How much: _____ Day / Week	
Any Surgeries: ☐ Yes ☐ No If yes, please explain:		

Please answer the following questions honestly so we can do our best to help you reach your goals.

What changed that caused the weight gain (if anything)? _____

What's the main reason you are seeking treatment at this time? _____

What are your goals about weight control and management? _____

What do you consider to be your ideal weight? _____

When was the last time you were at your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is the hardest part about managing your weight? _____

What have you tried in the past that has failed? _____

How committed are you to achieving your weight loss goals? _____

What's the biggest obstacle preventing you from reaching/maintaining your ideal weight? _____

How would losing weight improve your overall health, confidence, or quality of life? _____

Continued on next page…

Please fill in all previous programs that you have tried in order to lose weight. Indicate dates and length of time and any medications:

Program	Date	Medication	Dose/Freq.
Weight Watchers			
Atkins			
Keto Diet			
Diet Pills			
Nutrisystem/Jenny Craig			
Other			

Have you maintained weight loss for up to a year with any of these programs? _____

What did NOT work for you about these programs? _____

What has been your lowest _____ and highest _____ weight as an adult?

What's more important inches lost or pounds? _____

What would stop you from a weight loss program? _____

Do you binge eat?	☐ Yes	☐ No
Do you suffer from uncontrollable cravings?	☐ Yes	☐ No
Do you feel that food controls you?	☐ Yes	☐ No
Do you eat because of your emotions?	☐ Yes	☐ No
Do you eat between meals?	☐ Yes	☐ No
What do you eat between meals?		
Do you feel that your eating behaviors are normal?	☐ Yes	☐ No
Briefly describe your daily eating behaviors:		
Does your family support your weight loss efforts?	☐ Yes	☐ No
Can you remember being at your ideal weight?	☐ Yes	☐ No
What do you remember most about it?		
Scale of 1-10, your commitment to weight loss (1 = Not Committed, 10 = Fully Committed):		

List ALL medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?

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.

PREMIER
TOTAL HEALTHCARE

CONSENT FOR WEIGHT LOSS CONSULTATION

I authorize Premier Total Healthcare, medical staff and physicians to assist me in my weight loss reduction efforts.

POTENTIAL RISKS WITH SEMAGLUTIDE OR TIRZEPATIDE

Prolonged vomiting

Patients on Semaglutide or Tirzepatide can develop gastroparesis, where the stomach stops moving, and patients vomit considerably. This can lead to dehydration and electrolyte imbalances. Stop using Semaglutide or Tirzepatide and call your healthcare provider right away if you have vomiting that persists for more than a day.

Inflammation of your pancreas (pancreatitis)

Stop using Semaglutide or Tirzepatide and call your healthcare provider right away if you have severe pain in your stomach area (abdomen) that will not go away, with or without vomiting. You may feel the pain from your abdomen to your back.

Changes in vision

Tell your healthcare provider if you have changes in vision during treatment with Semaglutide or Tirzepatide.

Low blood sugar (hypoglycemia)

Your risk for getting low blood sugar may be higher if you use Semaglutide or Tirzepatide with another medicine that can cause low blood sugar, such as sulfonylurea or insulin. Signs and symptoms of low blood sugar may include dizziness or lightheadedness, blurred vision, anxiety, irritability or mood changes, sweating, slurred speech, hunger, confusion or drowsiness, shakiness, weakness, headache, fast heartbeat, and feeling jittery.

Kidney problems (kidney failure)

In people who have kidney problems, diarrhea, nausea, and vomiting may cause a loss of fluids (dehydration), which may cause kidney problems to get worse. It is important for you to drink fluids to help reduce your chance of dehydration.

Serious allergic reactions

Stop using Semaglutide or Tirzepatide and get medical help right away if you have any symptoms of a serious allergic reaction, including swelling of your face, lips, tongue, or throat; problems breathing or swallowing; severe rash or itching; fainting or feeling dizzy; or very rapid heartbeat.

MONITORING, PHOTOS & IDENTIFICATION

I understand that at each of my appointments, my weight, my blood pressure, and my pulse will be recorded. My photos will be taken when I start the program, as well as when I either finish or reach my goal weight. These photos will be kept confidential and in my chart unless I specify that they may be published for advertising purposes. A photocopy of my driver's license, state-issued identification card, or passport will be taken and kept in my chart for physical identification.

PRESCRIPTION MEDICATION

Many of the medications that are prescribed by the medical provider of this establishment, and all subsidiaries are deemed as controlled substances and must be monitored regularly. All patients are required to have an appointment with a medical provider in order to receive any prescription refills.

ADDITIONAL RISK & TREATMENT INFORMATION

Thyroid tumors / MTC

Semaglutide or Tirzepatide injection may increase the risk that you will develop tumors of the thyroid gland, including medullary thyroid carcinoma (MTC; a type of thyroid cancer). Tell the doctor if you or anyone in your family has or has ever had MTC or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2; condition that causes tumors in more than one gland in the body). If you experience any of the following symptoms, call your doctor immediately: a lump or swelling in the neck; hoarseness; difficulty swallowing; or shortness of breath.

OTHER POTENTIAL CONSIDERATIONS

- Allergic reactions to prescribed medication and supplements
- Side effects of medication
- Inconvenience of lifestyle changes

I understand that some medications and supplements may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain existing disease conditions. I do not expect my medical provider to be able to anticipate and explain all risks and potential complications. I wish to rely on the judgment of the medical providers in recommending programs that they feel are in my best interest, based on the available knowledge.

I have the opportunity to ask questions and discuss with the medical staff to my satisfaction:

- My condition
- The nature, purpose, and potential benefit of the proposed medical weight loss program(s)
- The potential risks associated with the medical weight loss program(s)
- The probability of those risks occurring
- The likelihood of success
- The possible consequences if advice is not followed and/or no weight loss programs are undertaken

FEMALE PATIENTS ONLY

I certify that I am not pregnant at this time, and if I do become pregnant, I will immediately stop the weight loss program along with any weight loss medication and notify my medical provider.

ADDITIONAL OFFICE POLICIES

APPOINTMENT TIMES

New Patient appointments typically take an hour to an hour and a half from check-in to check-out. Follow-up appointments usually take 30 minutes from check-in to check-out.

LAB WORK

Lab work is mandatory for all weight loss programs. I understand that my lab work needs to be completed within the first week following my initial appointment. My lab work can be billed through my insurance company depending on the plan; otherwise, I was made aware that the bloodwork will be an additional $70.00.

Continued on next page…

CONSENT TO BE SEEN VIA TELEMEDICINE

"Telemedicine Appointment" means that you may be evaluated and treated by a health care provider from a different location via electronic communication. Since this may be different than the type of office visit with which you are familiar, it is important that you understand and agree to the following statements:

1. I understand that by consenting to be seen via telemedicine appointment, I will be seen by a staff member of Premier Total Healthcare, who will be at a different location than me.

2. I understand that I am responsible for being in a location, and on a device that has a strong and reliable internet connection for the duration of my telemedicine appointment without any interruptions.

OFFICE AND FINANCIAL POLICIES

PAYMENT POLICY

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE; however, some services may require a deposit in advance. We only accept payments in the form of cash, VISA, MasterCard, American Express. There is a 3.% service fee added to any credit card transaction. We do not accept checks.

INSURANCE POLICY

We do NOT participate with any insurance companies. We are not able to bill your insurance and cannot accept payment from insurance for the services performed or prescriptions received. The medical providers do not use diagnosis codes or CPT codes, and because of this, we are unable to complete forms for patient reimbursement from insurance companies.

ELECTRONIC RECORDING

To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits.

SERVICES

I understand that Premier Total Healthcare reserves the right to refuse treatment to and/or dismiss a client from any service, at any time. I also understand that I may not be a candidate for certain medical services, and it is at the full discretion of the medical provider to determine whether I am a candidate for any service provided.

GUARANTEE

As in any procedure, treatment or program, there is no guarantee of any results. Results will vary based on each individual patient.

REFUND POLICY

We will provide patients with prescription medication and are subjected to state and federal laws. These laws do not permit us to restock sold items and accept returned prescription medications for refund. All SALES ARE FINAL. WE CANNOT TAKE BACK PRESCRIPTION MEDICATION. Before a service is performed, please consider all the required protocols and side effects. We are committed to patient satisfaction and are available to answer any questions or concerns you may have regarding the services we offer.

Patient's Name _____ **Date** _____

Patient's 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.

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.