



Dear New Patient of Holistic Family Medicine,

This letter is to welcome you to Holistic Family Medicine, LLC. We are located directly behind Macy's Furniture at 9325 Glades Road, Suite 104. You may want to plan on arriving early to account for difficulty finding the office, traffic, parking, and filling out any additional registration forms, allowing you full time with the doctor.

Enclosed is a copy of our new patient questionnaire. It can take between 1-2 hours to fill this form out completely and we have found that a detailed patient history is the most effective way in discovering the root cause of troublesome symptoms. Please be sure to complete this form ahead of time and bring it to your visit. You may bring an MP3 recorder or an audio tape or blank CD to record your sessions. We have found that patients love having the benefit of being able to re-listen to their consultations with Dr. Woliner, as he is very thorough. If necessary, our office can provide you a blank CD or audio tape for the cost of \$5.00.

Please understand that in order to get accurate and reliable data, all Lab work must be drawn in office. The only exception is Medicare patients, due to Medicare guidelines.

As you are aware, Dr. Woliner has OPTED OUT of Medicare and is an OUT OF NETWORK PROVIDER for all insurance companies. All patients are expected to pay at time of service for their care. We are not responsible for any claims that are unpaid or rejected.

Again, welcome to Holistic Family Medicine, LLC. We look forward to seeing you soon and helping you achieve the best health you can.

Sincerely,

**Kenneth N. Woliner, M.D., A.B.F.M.**



## OFFICE POLICIES

1. Dr. Woliner is an out of network provider who does not accept insurance and also does not accept Medicare. The fee for service is due at the time of each visit. No guarantees have been made to me with regard to reimbursement.
2. The financial agreement for our office is the following: all fees for any services and/or products are due at the time of your visit. Any charge backs from your credit card payment will result in the immediate collection process and a negative rating to your credit until satisfied.
3. All Lab work must be done in our office to ensure accurate and reliable data, with Medicare patients being the only exception.
4. If you are unable to keep your appointment for any reason, we require that you call as soon as possible to reschedule your visit, and 2 BUSINESS DAYS IS REQUIRED FOR CANCELLATION.
  - Appointments must be canceled with the office staff only.
  - If you have not given us 2 business day's notice of cancellation, you will be responsible for the visit.
  - If you do not call and miss your appointment you will be responsible for the full amount of the visit.
5. Please make sure you have enough refills for all your Medications to last until your next appointment.
6. Refills need to be written by the doctor during your office visit, not by phone or Fax. We will make exceptions for some patients with a 48 hour notice.
  - I understand and agree \_\_\_\_\_.
7. It is my responsibility to carry a current medication/vitamin list to all my appointments. I will need to present this list to the front desk and prior to seeing the doctor.
8. Please refrain from wearing any perfume or body sprays on the day of your visit, due to our Odor Sensitive patients.
9. I agree that, in the event of non-payment, I will bear the cost of collection and/or court costs and if reasonable legal fees should this be required.
10. Dr Kenneth Woliner owns the copy right of anything I may post to the internet regarding him or Holistic Family Medicine LLC I understand and agree\_\_\_\_\_.

We appreciate your cooperation and look forward to serving your health needs.

I have read this form and fully understand it.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## Medicare Private Contract

*IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D*

This contract is entered into by and between Kenneth Woliner, M.D. (hereinafter called "physician"), whose principal medical office is located at 9325 Glades Road, #104, Boca Raton, FL 33434 and \_\_\_\_\_ (hereinafter called "beneficiary"), and shall become effective on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and shall be effective for the "opt out period" and automatically renewed each time the physician renews his opt out contract with Medicare, in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

### Physician Obligations

The physician acknowledges that he is not excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that he must enter into a contract for each opt-out period.

### Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that **no payment will be provided by Medicare** for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.





## MUTUAL AGREEMENT

Dr. Kenneth Woliner, M.D. and Holistic Family Medicine, LLC (collectively labeled "Physician") agree to provide treatment to: \_\_\_\_\_ ("Patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation. Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS \_\_\_ DAY OF \_\_\_\_\_, 201\_\_\_. \_\_\_\_\_ (PATIENT)

Dr. Kenneth Woliner M.D. and Holistic Family Medicine, LLC.



## INFORMED CONSENT FOR COMPLIMENTARY AND ALTERNATIVE HEALTH TREATMENTS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

As per s. 456.41, Florida Statutes, A health care practitioner who offers to provide a patient with a complementary or alternative health care treatment must inform the patient of the nature of the treatment and must explain the benefits and risks associated with the treatment to the extent necessary for the patient to make an informed and prudent decision regarding such treatment option. In compliance with this subsection:

- (a) The health care practitioner must inform the patient of the practitioner's education, experience, and credentials in relation to the complementary or alternative health care treatment option.
- (b) The health care practitioner may, in his or her discretion, communicate the information orally or in written form directly to the patient or to the patient's legal representative.
- (c) The health care practitioner may, in his or her discretion and without restriction, recommend any mode of treatment that is, in his or her judgment, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of his or her license.

This informed consent form serves to indicate in the patient's care record that this health care practitioner has chosen to communicate information regarding benefits and risks associated with complementary and alternative health care treatments **orally**, at each and every visit, directly to the patient. The patient will have ample opportunity to ask questions, and receive answers to these questions, before, during, and after any test or treatment offered by this health care practitioner.

\_\_\_\_\_  
Patient Signature  
(legal guardian if patient < 18 yrs old)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kenneth N. Woliner, M.D. , A.B.F.M.  
Practitioner Signature

\_\_\_\_\_  
Date





## MEDICAL QUESTIONS

(Please Fill in Gaps, Circle Options When Given a Choice)

**(To Check box: Double click on box and select "Checked")**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Who can we thank for this referral? \_\_\_\_\_

CC What is the main reason for your consultation today? \_\_\_\_\_

Was this in relation to an automobile or work accident?  Y  N

HPI (o) When did it begin? Associated with? \_\_\_\_\_

(p) Where are your symptoms the worst? \_\_\_\_\_

(q) How do you describe their quality? \_\_\_\_\_

(r) Do they radiate anywhere else? \_\_\_\_\_

(s) What other symptoms do you have? \_\_\_\_\_

(t) What treatments have you tried so far? \_\_\_\_\_

Are there any other problems bothering you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PMH Please list any other medical conditions you have been diagnosed as having (ie. heart attack, cholesterol, hypertension, stroke, diabetes, osteoporosis, allergies, depression, multiple sclerosis, lupus, glaucoma, arthritis, irritable bowels, reflux disease, aids, hepatitis, back/neck pain / disc disease, Candida/yeast, food allergies, fibromyalgia, chronic fatigue, other)

\_\_\_\_\_

\_\_\_\_\_

Please list all surgeries (including tonsils and caesarians) \_\_\_\_\_

\_\_\_\_\_

All hospitalizations/auto accidents: \_\_\_\_\_

Allergies/intolerances (Drugs, gluten, latex, etc) \_\_\_\_\_

Medications: Name/Dose/How taken/Why \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Vitamins/Herbals/OTC Meds (including aspirin) Name/Dose/How taken/Why

\_\_\_\_\_

\_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Preventive Medicine Exams** (Date of last exams. Mo/Yr - leave blank if never had exam)

Physical exam: \_\_\_\_\_ / \_\_\_\_\_ Chest x-ray: \_\_\_\_\_ / \_\_\_\_\_  
Blood work: \_\_\_\_\_ / \_\_\_\_\_ EKG: \_\_\_\_\_ / \_\_\_\_\_  
Bone density scan (dexa): \_\_\_\_\_ / \_\_\_\_\_ Stress test: \_\_\_\_\_ / \_\_\_\_\_  
Colonoscopy: \_\_\_\_\_ / \_\_\_\_\_

Do you have access to these results?  Y  N  
(Sometimes it is very useful to get copies of your old labs, and/or borrow the actual x-ray for specific conditions.)

Were they normal?  Y  N If no, describe: \_\_\_\_\_

**Females Only**

Menarche: (Mo/Yr) \_\_\_\_\_ / \_\_\_\_\_ Cramps?  Y  N  
Cycle:  Regular  Irregular  Heavy  Painful History of ovarian cysts?  Y  N  
Menopause date: (Mo/Yr) \_\_\_\_\_ / \_\_\_\_\_ Endometriosis?  Y  N  
Cycle length: \_\_\_\_\_ Breast cysts?  Y  N  
Spotting between periods?  Y  N Frequent yeast infections?  Y  N  
PMS Symptoms (water retention, breast tender, irritability, depression, headaches, mood swings, food cravings, etc)

Number of pregnancies: \_\_\_\_\_ Complications?  Nausea  Toxemia  Miscarriage  Other  
Last annual women exam: (pap/breast exam) \_\_\_\_\_ / \_\_\_\_\_ Ever abnormal?  Y  N  
Mammo/Thermography: \_\_\_\_\_ / \_\_\_\_\_ Normal?  Y  N  
Menopause Symptoms (hot flashes, night sweats, insomnia, anxiety, vaginal dryness, skin dryness, low libido, arthritis)

Are you sexually active?  Y  N Do you use birth control?  Y  N  
Is your libido good?  Y  N  
Were you ever physically or sexually abused?  Y  N (If yes, describe)

**Males Only**

How often do you get up at night to urinate? \_\_\_\_\_  
Urine volume:  Lg Amt  Sm Amt Prostate problems?  Y  N  
Any impotency problems?  Y  N LAST prostate exam \_\_\_\_\_ / \_\_\_\_\_  
Sores on penis?  Y  N Are you sexually active?  Y  N  
Penile discharge?  Y  N Do you use birth control?  Y  N Type: \_\_\_\_\_  
History of a Venereal disease?  Y  N Is your libido good?  Y  N

Were you ever physically or sexually abused?  Y  N (If yes, describe)

**Childhood** (Adults, please complete if you remember your childhood)

Pregnancy/delivery normal?  Y  N  
Premie?  Y  N  
Do you get immunized?  Y  N If so, please bring in copy of shot record. (If available)  
Have you had chicken pox?  Y  N  
Frequent infections?  Y  N How often per year? \_\_\_\_\_  
Bedwetting?  Y  N  
Hyperactivity?  Y  N



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Fh Has anyone in your family had any major illnesses (ie. cancer, heart disease, cholesterol, stroke, diabetes, thyroid disease, arthritis, kidney disease, liver disease, depression, alzheimer's, etc.)

Mother \_\_\_\_\_ Grandparents \_\_\_\_\_  
Father \_\_\_\_\_ Distant Relatives \_\_\_\_\_  
Brothers/Sisters \_\_\_\_\_ Children \_\_\_\_\_

Sh Tobacco: Cigarettes per: Day \_\_\_\_ Week \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_ Date quit \_\_\_\_ / \_\_\_\_

Alcohol: (Drinks per day) \_\_\_\_\_

Caffeine: (Cups per day) \_\_\_\_\_

How often do you stretch?  Every hour  Daily  Weekly  Occasionally  Never

How often do you do aerobic exercise? \_\_\_\_ /week \_\_\_\_ min per day

Do you lift weights?  Y  N \_\_\_\_ /week \_\_\_\_ min per day

### Diet

Write down what you eat and drink for a full day (everything including water, chewing gum, etc.)

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snack: \_\_\_\_\_

Do you have a special diet?  Y  N

(ie. vegetarian, vegan, ovo-lacto, dairy restricted, blood type diet, Kosher, atkins, sugar busters, etc.)

Any foods you avoid?  Y  N \_\_\_\_\_

Do you have symptoms immediately after eating?  Y  N \_\_\_\_\_

### Social/Relationships

Single  Married  Divorced  Separated  Widowed

Number of children: \_\_\_\_\_ Names & Ages: \_\_\_\_\_

Pets:  Y  N If yes, describe: \_\_\_\_\_

Stress:  Low  Moderate  High Stress reduction activities: \_\_\_\_\_

Job:  Love it  Hate it  Too many hours  Too much responsibility

Major life changes: (ie. Death in family, Change of job, Change of home, etc.)

Hobbies/Leisure activities: \_\_\_\_\_

Do you feel spiritually connected (ie. religion, meditation, etc.)  Y  N

Environmental exposures:  Secondhand Smoke  Pesticides  Seasonal Allergies

Mercury Amalgam dental fillings:  Y  N If yes, how many: \_\_\_\_\_

Artificial joints/implants  Y  N

Toxic metal exposure at work/home:  Y  N If yes, how many: \_\_\_\_\_

Do odors bother you?  Y  N

Travel outside the u.s.?  Y  N Which countries? \_\_\_\_\_



## REVIEW OF SYMPTOMS CHECKLIST

(Please check off all symptoms you have, even if they are not your "major" problem. Subtle symptoms across many organ systems can often combine to form a pattern that identifies a cause of your major symptoms)

**(To Check box: Double click on box and select "Checked")**

### General

- Brain fog
- Cold hands/feet
- Cold intolerance
- Convulsions
- Dizziness
- Drowsiness
- Fainting spells
- Fatigue
- Fever
- Food allergy
- Frequent infections
- Hallucinations
- Heat intolerance
- Memory loss
- Sweating, excessive
- Swollen glands
- Trouble falling asleep
- 3 am - 4 am awakening
- Excessive sleep
- H/o metal toxicity
- H/o auto accident

### Skin

- Acne
- Athlete's foot
- Blush easily
- Brittle nails
- Bruise easily
- Corns/calluses
- Excessive hair growth
- Fluid retention
- Hair loss/thinning
- Hives
- Ingrown nails
- Jaundice/yellow skin
- Nail fungus
- Numbness/tingling
- Pale skin
- Psoriasis
- Rash
- Skin itchy, dry
- Skin Tags
- Thickening of skin
- Warts

### Nutrition/Metabolism

- Craving bread
- Craving ice
- Craving sugar
- Excessive eating
- Excessive thirst
- H/o Phen/Fen use
- Hypoglycemia
- Ideal body weight \_\_\_\_\_
- Loss of appetite
- Short stature
- Slow metabolism
- Weight gain, unwanted
- Weight loss, unwanted

### Head and neck

- Allergies
- Bad breath
- Canker sores (inside mouth)
- Cough
- Cough, bloody
- Cough, productive
- Dry eyes
- Dyslexia
- Excessive ear wax
- Fever blisters (outside mouth)
- Freq sinus infections
- Gums bleed
- Headache
- Hiccups
- Mouth breathing
- Neck mass
- Nosebleeds
- Poor night vision
- Ringing in ears
- Slurred speech
- Sneeze frequently
- Snoring
- Throat pain
- Trouble smelling things
- Vision loss of
- Voice, hoarse
- Voice, loss of

### Chest, heart and lungs

- Breast lump
- Chest pain
- Heart murmur
- Low blood pressure
- Lymph node swelling
- Palpitations
- Rapid heart beat
- Short of breath
- Short of breath when sleeping
- Wheezing

### Digestive

- Blood in stools
- Change in bowel habits
- Constipation
- Difficulty in swallowing
- Fecal incontinence
- Flatulence, gas pain
- Heartburn
- Nausea
- Nausea with vomiting

### Abdomen/Pelvis

- Abdomen / pelvis
- Abdominal pain
- Bedwetting
- Blood in urine
- Flank pain recurrent
- Hemorrhoids
- Kidney stones
- Painful urination
- Penile discharge
- Post-void dribbling
- Testicular pain
- Urinary frequency
- Urinate at night?
- Urine incontinence
- Urine retention
- Urine stream slowed?



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Review of symptoms (continued):

Muscles and bones

- Calf cramps
- Carpal tunnel
- Difficulty walking
- Gout
- Hand cramps
- Lack of coordination
- Loss of height
- Muscle spasms
- Muscle stiffness
- Poor posture

Abnormal examinations

- Abnormal ana
- Abnormal biopsy
- Abnormal cholesterol
- Abnormal clotting
- Abnormal chest x-ray
- Abnormal ekg
- Abnormal glucose test
- Abnormal liver test
- Abnormal mammogram
- Abnormal pap smear
- Abnormal tb test
- Abnormal psa
- Abnormal thermogram
- Abnormal thyroid scan
- Abnormal thyroid u/s

Other

- Troublesome old injury?
- Food allergy
- H/o mva

Advanced Directives (living will)

The State of Florida law requires each health care provider to ask whether you have advanced directives (living will).

Have you made an advanced directive?  Y  N If yes, please describe:

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Space available for explanations to any question above:

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We appreciate your efforts. To improve the quality of care at our office, please answer just one more question.

How long did it take you to fill out this questionnaire? \_\_\_\_\_



## DIET AND LIFESTYLE DIARY

Please take the time to complete this survey carefully and accurately.

- List in detail, the quantity and the exact nature of all foods and beverages you consume (such as frozen, canned, fresh, etc.) mention also if the foods are raw or cooked. Be sure to list all the beverages, all fats or oils, and any condiments you consume (such as mayonnaise, mustard, relish, etc.)
- Complete the exercise activity portion at the bottom listing the type of exercise, it's duration, and your pulse before and during the activity, if you know it.
- And finally, record any periods of relaxation during your day.

DAY 1			
<b>Date:</b>	<b>Week:</b>		
<b>Morning Meal</b>	Time:		
Snack:	Time:		
<b>Noon Meal</b>	Time:		
Snack:	Time:		
<b>Evening Meal</b>	Time:		
<b>Water:</b> (Cups per day)			
<b>Other Beverages:</b>			
<b>Fats/Oils:</b>			
<b>Condiments:</b> (sugar, salt, spices, herbs)			
<b>Exercise:</b>			
Type:	Duration:	Pulse Before:	Pulse After:
<b>Relaxation:</b>			
Type:	Duration:		



DAY 2			
<b>Date:</b>		<b>Week:</b>	
<b>Morning Meal</b>		Time:	
Snack:		Time:	
<b>Noon Meal</b>		Time:	
Snack:		Time:	
<b>Evening Meal</b>		Time:	
<b>Water:</b> (Cups per day)			
<b>Other Beverages:</b>			
<b>Fats/Oils:</b>			
<b>Condiments:</b> (sugar, salt, spices, herbs)			
<b>Exercise:</b>		Duration:	Pulse Before:
Type:			Pulse After:
<b>Relaxation:</b>		Duration:	
Type:			

DAY 3			
<b>Date:</b>		<b>Week:</b>	
<b>Morning Meal</b>		Time:	
Snack:		Time:	
<b>Noon Meal</b>		Time:	
Snack:		Time:	
<b>Evening Meal</b>		Time:	
<b>Water:</b> (Cups per day)			
<b>Other Beverages:</b>			
<b>Fats/Oils:</b>			
<b>Condiments:</b> (sugar, salt, spices, herbs)			
<b>Exercise:</b>		Duration:	Pulse Before:
Type:			Pulse After:
<b>Relaxation:</b>		Duration:	
Type:			



## CONSENT FOR RELEASE

### For:

Name: \_\_\_\_\_  
Social Security: \_\_\_\_\_  
DOB: \_\_\_\_\_

### Form in which Information/Record is to be Released:

- Written
- Fax

### What Information/Reports Are to be Released:

- Initial Medical Examination
- Progress Notes
- Discharge Summaries
- Counselor/Therapist Evaluation
- X-Ray/CT/MRI Scan(s)
- Lab Reports/Pathology

### Released To:

Holistic Family Medicine, LLC  
9325 Glades Road, Suite 104  
Boca Raton, FL 33434  
Phone: 561.314.0950  
Fax: 561.314.0957

This information, including diagnosis and record of any examination or treatment rendered to me during the period of time from \_\_\_\_\_ to \_\_\_\_\_, to include any Federal and State protected information under Florida Statute 394.459 (9) Psychiatric Information, Florida Statutes 397.053 & 396.112 Drug and/or Alcohol Abuse Information, and Florida Statute 381.609(2) Human immunodeficiency Virus test results (Aids related Conditions).

I understand by approving the release of information in the form of a Fax, then confidentiality can not be assured; and I accept the risk that confidentiality may be breached when faxing information.

I understand that this authorization shall expire ninety (90) days from the date of my signature below. I hereby release Holistic Family Medicine, LLC and its employees from any and all liability that may arise from this release of information.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

This authorization may be revoked at any time upon written notification by the signatory or patient but revocation has no effect on action previously taken.



**HIPAA CONSENT**  
Holistic Family Medicine, LLC  
Patient Consent Form

Our Notice of Privacy Practices (9 pages) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your consent.

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Description of Representative's Authority: \_\_\_\_\_



**Dear Patients:**

“Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.” Florida Statutes Section 458.320 (5) (6) 4.

Sincerely,

**Kenneth N. Woliner, M.D., ABFM**

I \_\_\_\_\_ have read and understand the notice provided with respect to malpractice insurance. I hereby consent to treatment by any of the physicians listed above who have informed me of their lack of medical malpractice coverage; and to the treatment by other members of the medical group.

\_\_\_\_\_  
Patient’s Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness’ Name

\_\_\_\_\_  
Date



## DIRECTIONS TO OUR OFFICE

Holistic Family Medicine, LLC  
Glades Medical Center  
9325 Glades Road, Suite # 104  
Boca Raton, Florida 33434



### Directions:

#### **From I-95:**

Take I-95 to Glades Road, exit and go west. Continue west, pass the Florida Turnpike. Proceed past Lyons Road, on the right hand side you will approach City Mattress. Make a right between City Mattress and Macy's Furniture. We are directly behind Macy's Furniture Gallery. The address is not visible from Glades Road.

#### **From the Turnpike:**

Take the Florida Turnpike to Glades Road, exit and go west. Proceed past Lyons Road, on the right hand side you will approach City Mattress. Make a right between City Mattress and Macy's Furniture. We are directly behind Macy's Furniture Gallery. The address is not visible from Glades Road.

**We Look Forward To Seeing You!**