ANDROLOGIX™ HEALTH AND WELLNESS

THE SOZO GROUP™ INNOVATION | INSPIRATION | INTEGRITY

Medical Treatment Agreement

This agreement between ____ (Patient) and **Andrologix Health and Wellness, LLC. and their parent company Sozo Group, LLC** (Andrologix) establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. Andrologix and Patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/physician relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

THE PATIENT ACCEPTS AND AGREES TO THE FOLLOWING CONDITIONS:

01. I understand that the medical treatment offered by Andrologix and their Physician(s) is not accompanied by any claims, guarantees, promises or warranties.
02. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
03. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it's against the law to do so.
04. I will immediately report any adverse side effects related to the use of my medication to Andrologix and discontinue use until advised to resume usage by Andrologix.
05. I understand that the Andrologix Physician (MD) and/or Licensed Physician's Assistant (PA-C) are available for questions and/or concerns during normal business hours throughout the course of my treatment.
06. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
07. I agree that these medications are for my personal use only and no other purpose and I will not share, sell, or trade my medications.
08. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.
09. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I agree to contact Andrologix 4-6 weeks into the start of my therapy (and every 3 months thereafter) to arrange for any follow-up blood testing and/or an office visit/consultation as required by the Andrologix physician.
11. I agree and understand that completing the required forms, lab work and exams doesn't automatically qualify me for treatment. Only the prescribing physician can determine if I qualify.
12. I agree that the Andrologix patient/physician relationship is not intended to replace the existing relationship with my current primary care provider (PCP) and my Andrologix treatment will be in conjunction with the care provided by my current PCP.
13. I have been made aware that some symptoms of clinical depression are similar to those experienced with low testosterone. If I or my family members have a history of depression, it is recommended that I seek treatment before starting an HRT program.

By checking this box, I acknowledge and understand that charges will appear on my Credit Card Statement as "SOZO GROUP LLC", the parent company of Andrologix Health & Wellness.

______________________________ Patient's Signature

______________ Date

Most patients are very anxious to hear the results of their lab tests or other determinations made by our medical staff regarding their treatment. Due to a physician's schedule, communication of the results, especially if they are within normal ranges, is sometimes delayed. Although all Andrologix Health and Wellness personnel, both professionals and non-professionals, are part of the Health Care Operations of the practice, and therefore do not require a specific HIPAA consent form, Andrologix Health and Wellness takes the confidentiality of your personal health information very seriously and does not permit its personnel who are not directly involved in your medical assessments and treatment with access to your medical records without your written consent. By signing this form, you will give permission to allow your personal Andrologix Client Liaison, or other administrative staff member, to communicate to you via phone, email, text message, in writing, or in person, protected health information pertaining to your medical care.

This consent form does not allow Andrologix Health and Wellness to share your health information with any third-party for any reason. **It simply authorizes our administrative staff to convey information from our medical staff to you, at your request.** Understand that administrative staff cannot answer specific questions about the meaning of test results or treatment modalities, and if you have such questions after receiving the results, your client liaison, or other administrative staff member, will have a physician or other qualified health professional contact you to answer your questions.

Authorization for Andrologix to Release Health Information to Myself

I, ____, hereby give my consent for Andrologix Health and Wellness LLC, their parent company the **SOZO GROUP, LLC.** (Andrologix), and their non-medical professional and administrative staff to disclose my protected health information (PHI) to me pertaining to my medical results and treatment.

With this consent, my Andrologix Client Liaison, or other administrative staff, may communicate to me by phone, email, text message, in writing, or in person, information that assists the practice in carrying out operations related to my treatment; such as, appointment reminders, billing issues, and communications related to my clinical care, including laboratory test results. **I acknowledge that such liaison or staff cannot answer specific questions about the results or course of my treatment as they are not a health professional, and any opinions and/or casual conversation they might gratuitously offer are not to be construed as medical advice, and that I can request a physician or other health professional to contact me to answer my questions.**

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that this form is not required under the HIPAA privacy rule, but if I choose not to consent, or later revoke consent, Andrologix Health and Wellness may be unable to continue to provide treatment to me, but they will not do so without affording me a reasonable time, not longer than thirty days, to obtain a successor physician/practice.

______________________________________	____________________
Patient's Signature	Date

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Telehealth Consent Form

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has given me instructions on how the video conferencing technology will be used to conduct such a consultation. I understand that it is not the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my primary health care provider. These individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence and will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me and chose to participate in a telemedicine consultation. I understand that some parts of the exam involving physical and lab tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. I have been given the opportunity to ask questions of the health care provider regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

____
Patient's Name

____ ____________________
Patient's Signature Date signed