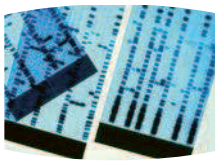
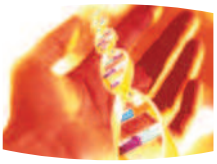
OPTIMAL HEALTH MD
AGE MANAGEMENT CENTERS

# PATIENT MEDICAL MANAGEMENT AND AUTHORIZATION FORMS





OPTIMAL HEALTH AGE MANAGEMENT MD CENTERS

## THERAPY PROGRAM ORDER PROCEDURES

YOUR CONSULTANT'S NAME: _____

- ☐ READ AND SIGN MEDICAL MANAGEMENT AGREEMENT
- ☐ COMPLETE QUALITY OF LIFE ASSESSMENT
- ☐ COMPLETE CONFIDENTIAL MEDICAL HISTORY INFORMATION
- ☐ READ AND SIGN PATIENT AUTHORIZATION AGREEMENT
- ☐ SCHEDULE PHYSICAL EXAMINATION

## OPTIMAL HEALTH & REJUVENATION CENTER CONTACT INFORMATION:


- **MAIL INFORMATION:**
  1250 E. Hallandale Beach Blvd,
  Suite 505
  Hallandale Beach, FL 33009

- **DIRECT LINE:**
  (954) 404-6815
- **FAX LINE:**
  (954) 404-6819
- **TOLL FREE LINE:**
  (877) 224-3633

# MEDICAL MANAGEMENT AGREEMENT

This agreement between _____ _ (patient) and Optimal Health MD, LLC. (OHMD) establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or'' scheduled" medications. OHMD 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:

1. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood/lab work, and physical examination.They are to be used exclusively for treatment of these diagnoses.
2. 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 is against the law to do so.
3. I will immediately report any adverse side effects related to the use of my medication to OHMD and discontinue use until advised to resume usage by OHMD.
4. I understand that the OHMD 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.
5. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
6. 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.
7. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.
8. I agree and understand that federal regulations prohibit the return of prescribed medications.
9. I agree to contact OHMD 4-6 weeks into the start of my therapy (and every 6 months thereafter) to arrange for any follow up b l o o d testing and/or an office visit/consultation as required by the OHMD physician
10. I agree that the OHMD patient/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and my OHMD treatment will be in conjunction with the care provided by my current PCP.
11. I certify upon my oath, that I am not a member of any law enforcement agency engaged in any kind of investigation of Optimal Health Rejuvenation Center. I am not collecting investigation information for any third party or involved in entrapment of any manner whatsoever with regard to Optimal Health Rejuvenation Center. By signing this agreement I give up any right to testify in court for any law enforcement agency. Failure to sign this agreement will eliminate you from obtaining a medically supervised program.
12. I agree that I will use the medications prescribed for my personal use and they are to be used exclusively for the prescribed treatment and diagnoses. I will not used prescribed medications for the purpose of body building, physical development and/or as a performance enhancement subtance.

Patient's Signature: _____

Patient's Printed Name Date: _____ Date: _____

**Please FAX Completed Form to: (954) 404-6819**

*A prescription is required for the purchase of syringes in the following states: California, Connecticut, Delaware, Hawaii, Idaho, Illinois, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, & Rhode Island. Patients located in other States may be able to purchase syringes without a prescription at local pharmacies.

**HGH will only be dispensed from a licensed US Pharmacy with express delivery via FedEx**

OPTIMAL HEALTH MD
AGE MANAGEMENT CENTERS

# QUALITY OF LIFE ASSESMENT

**Patient Name:** _____ **Date:** _____

Listed below are some statements that people may make about themselves. Read the list carefully and put mark the YES box if the statement applies to you. Mark the box NO if it does not apply to you.

**Please answer every item. If you are not sure whether to answer YES or NO, mark whichever answer you think is most true in general.

| | | |
|---|---|---|
| I have to struggle to finish tasks: | YES ☐ | NO ☐ |
| I feel a strong need to sleep during the day: | YES ☐ | NO ☐ |
| I often feel lonely even when I am with other people: | YES ☐ | NO ☐ |
| I have to read things several times before they sink in: | YES ☐ | NO ☐ |
| it is difficult for me to make friends: | YES ☐ | NO ☐ |
| It takes a lot of effort for me to do simple tasks: | YES ☐ | NO ☐ |
| I have a difficult controlling my emotions: | YES ☐ | NO ☐ |
| I have difficulty controlling my emotions: | YES ☐ | NO ☐ |
| I often lose track of what I want to say: | YES ☐ | NO ☐ |
| I lack confidence: | YES ☐ | NO ☐ |
| I have to push myself to do things: | YES ☐ | NO ☐ |
| I feel as if I let people down: | YES ☐ | NO ☐ |
| I find it hard to mix with people: | YES ☐ | NO ☐ |
| I feel worn out even when I've not done anything: | YES ☐ | NO ☐ |
| There are times when I feel very depressed: | YES ☐ | NO ☐ |
| I avoid responsibilities if possible: | YES ☐ | NO ☐ |
| I avoid mixing with people I don't know well: | YES ☐ | NO ☐ |
| I feel as if I'm a burden to people: | YES ☐ | NO ☐ |
| I often forget what people have said to me: | YES ☐ | NO ☐ |
| I find it difficult to plan ahead: | YES ☐ | NO ☐ |
| I am easily irritated by other people: | YES ☐ | NO ☐ |
| I often feel too tired to do the things I ought to do: | YES ☐ | NO ☐ |
| I have to force myself to do all the things that need doing: | YES ☐ | NO ☐ |
| I often have to force myself to stay awake: | YES ☐ | NO ☐ |
| My memory lets me down: | YES ☐ | NO ☐ |

**Please make sure you answer YES or NO to every question

COMMENTS: _____

_____

**Please FAX Completed Form to: (954) 404-6819**

OPTIMAL HEALTH MD
AGE MANAGEMENT CENTERS

# CONFIDENTAIL MEDICAL HISTORY FORM 1/2

First Name: _____ Last Name: _____

Gender: Male ☐ Female: ☐ DOB: _____ Weight: _____ Height:

## SECTION 1

**Patient History: Do you have or have your ever had any of the following? If the answer to any is yes, please check and explain below**

| | | | | | |
|---|---|---|---|---|---|
| Any known deficiency including minerals and electrolytes: | Yes | No | Immune disorders: | Yes | No |
| Blood disorders: | Yes | No | Lactating: | Yes | No |
| Cancer: | Yes | No | Lung disorder: | Yes | No |
| Carpal Tunnel syndrome: | Yes | No | Neurologic disorders, Thyroid, Diabetes or other endocrine | | |
| Chemical Dependency: | Yes | No | disorder including insulin resistance, or diabetes: | Yes | No |
| Drug allergies: | Yes | No | Orthopedic or muscle disorder including fracture or joint disorders: | Yes | No |
| Edema/excess fluid retention: | Yes | No | Poor wound healing: | Yes | No |
| Emotional disorders: | Yes | No | Regularly exercise (if yes, describe in SECTION 2) | Yes | No |
| Genital-Urinary disorder: | Yes | No | Renal disease: | Yes | No |
| Glaucoma: | Yes | No | Surgery: | Yes | No |
| Heart Attack: | Yes | No | Upper respiratory: | Yes | No |
| Heart disease including Atherosclerosis, Angina, Heart Failure: | Yes | No | Are you pregnant or breastfeeding: | Yes | No |
| Hyperlipidemia: | Yes | No | Use of medications: (if yes, list medications in SECTION 2) | Yes | No |
| Hypertension: | Yes | No | Other illnesses: (if yes, list medications in SECTION 2) | Yes | No |

**Family History: Does a relative have or have ever had any of the following? If the answer to any is yes, please check and explain**

| | | | | | |
|---|---|---|---|---|---|
| Cardiovascular disease: | Yes | No | Lipid Disorder: | Yes | No |
| Diabetes, thyroid or other: | Yes | No | Other forms of cancer: | Yes | No |
| Endocrine Disorder: | Yes | No | Prostate cancer: | Yes | No |
| Hypertension: | Yes | No | Other illnesses: | Yes | No |

**Questions for Treatment: Do you have or have your ever had any of the following? If the answer to any is yes, please check and explain**

| | | | | | |
|---|---|---|---|---|---|
| Cold or heat intolerance: | Yes | No | Increasing sagging muscles or breasts: | Yes | No |
| Decreased desire and ability to exercise: | Yes | No | Increasing wrinkles: | Yes | No |
| Decreased energy or endurance: | Yes | No | Increasingly stressed: | Yes | No |
| Decreased sense of well-being: | Yes | No | Loss of concentration, sociability, activity: | Yes | No |
| Decreasing memory: | Yes | No | Loss of interest in sex: | Yes | No |
| Decreasing muscle strength: | Yes | No | Muscle loss: | Yes | No |
| Decreasing size of testicals: | Yes | No | Progressive osteoporosis, decreasing bone mass | | |
| Depression: | Yes | No | or stooped posture: | Yes | No |
| Difficulty sleeping: | Yes | No | Sagging, loose or thin skin: | Yes | No |
| Hot flashes: | Yes | No | Thinning or loss of hair: | Yes | No |
| Increased lack of drive: | Yes | No | Urogenital atrophy: | Yes | No |
| Increasing fat deposits about abdomen or thighs: | Yes | No | Vaginal dryness: | Yes | No |
| Increasing mood swings: | Yes | No | Weight loss: | Yes | No |

**Please explain any "Yes" answers on section 2**

Patient Signature _____ Date: _____

# CONFIDENTAIL MEDICAL HISTORY FORM 2/2

## SECTION 2

| Please explain any "Yes" answers in section 1 of the medical history form |
|---|
| |
| |
| |
| |
| |
| |
| |
| |
| |

| Please list any medication you are currently taking |
|---|
| |
| |
| |
| |
| |
| |
| |
| |
| |

Patient Signature _____ Date: _____

# PATIENT AUTHORIZATION AGREEMENT 1/2

I, the undersigned patient ("I" or "Patient"), hereby agree and expressly authorize Optimal Health MD, L.L.C., a Florida limited liability company, its officers, agents, members, managers, unit holders, affiliates, employees, attorneys, contractors and representatives (collectively, "Optimal Health MD"), to secure me a medical laboratory, physician/medical doctor ("Treating Physician") and dispensing pharmacy (collectively, "Medical Providers") to provide me diagnostic testing, medical care and prescribed pharmaceuticals based on my completed and accurate medical history form ("Medical History Form") and any laboratory diagnostic tests obtained through Optimal Health MD, pursuant to and subject to the terms and conditions of this Agreement. I understand that the Medical History Form becomes the Property of Optimal Health MD and it will have continuing access to and the right to copy and retain all portions of my medical record, subject to applicable law.

I understand that Optimal Health MD shall pay the Treating Physician on my behalf as an independent contracting physician (and not an agent or employee), to render me medical services from funds I pay to Optimal Health MD. I am aware that Optimal Health MD does not control or influence the treatment decisions of the Treating Physician with respect to my care. I authorize the Treating Physician to release or disclose to Optimal Health MD any of my medical information or history. If pharmaceuticals are prescribed by the Treating Physician, I authorize and instruct Optimal Health MD to arrange for such pharmaceuticals to be dispensed and sent to me by any pharmacy in my country of residence as permitted under applicable state, local or federal law.

I hold harmless and waive any and all claims or defenses I may have against Optimal Health MD and its Medical Providers for any harm or injury I sustain as a result of my failure to fully disclose all relevant facts about my physical and medical condition to Optimal Health MD or the Medical Providers, including, but not limited to, the information on the Medical History Form. I further hold harmless and waive any and all claims or defenses against Optimal Health MD or the Medical Providers for any harm, damage or injury I sustain as a result of or caused by any act or omission of the Treating Physician or any other party (including, any claim arising from the selection of the Treating Physician). I also hold Optimal Health MD and the Medical Providers harmless and waive any and all claims and defenses for injuries or illnesses I sustain as a result of my failure to comply with the method of treatment and dosage schedule prescribed by the Treating Physician or any other Medical Provider (whether resulting from my failure to disclose all relevant facts to said physician or other Medical Provider, as the case may be, or not).

I agree to immediately cease any medical treatment prescribed by the Treating Physician in the event of any adverse response or side effect arising from prescribed treatment and provide immediate written notice to Optimal Health MD via facsimile and U.S. Mail. I further agree to comply with prescribing instructions for use of any and all medications. I understand and acknowledge that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no promises, assurances, or guarantees have been made to me as to the result of diagnostic testing, analysis of test results, examination of medical history or treatment by Optimal Health MD or the Medical Providers. I understand that the hormone blood level objective sought to result from my hormone replacement therapy, as prescribed by my treating physician, may be the highest level of a standard reference range for my sex and age, or may be even higher hormone blood level than normally found in a person younger than myself. I understand that hormone replacement therapy for the purpose of elevating my hormone blood levels to the highest level of standard reference range for may age and sex, or above such range to the level of a younger person, is experimental and may not render any benefits, but may result in unknown adverse results. I am aware of the nature, risk, and possible alterative methods of treatment, possible consequences, and possible complications involved in my treatment. I understand that recombinant human growth hormone replacement therapy for adults involves the use of a medical drug approved for a different purpose in an effort to obtain a sought objective of medical treatment. Nevertheless, I consent to such care and treatment, and I execute this Agreement with the complete informed understanding and for the purpose of authorizing the Treating Physician, at his sole and absolute discretion, to administer to me for the relief of my body ailments and to enhance my physical condition and health. I consent to the receipt of any prescribed drug approved for medical use in the country of my residence. I understand that the methods of medical treatment offered or provided are not accompanied by any claims, guarantees or promises, either from Optimal Health MD or the Medical Providers.

I expressly agree that the jurisdiction and venue for any medical claim, legal or equitable claim of any type whatsoever, or any dispute regarding pharmaceuticals, physicians, physician services, medical laboratories or any services or products

# PATIENT AUTHORIZATION AGREEMENT 2/2

provided to me by Optimal Health MD or the Medical Providers shall exclusively be in Broward County, Florida. I consent to the transfer and removal of any claim or action brought by me against Optimal Health MD or the Medical Providers to jurisdiction in Florida. Further, I agree to pay all costs and reasonable attorney's fees incurred by any party against whom I bring a claim or action in violation of the terms of this Agreement or related to the transfer, removal, change of venue of any claim brought by me against any party to venue as such costs are incurred on a weekly basis, without exception or assertion of any legal or equitable defense on my part or any legal counsel obtained to represent me. Jurisdiction and venue for any action brought against me by Optimal Health MD or the Medical Providers shall be in Broward County, Florida.

I am aware that the therapies and laboratory blood testing services supplied by Optimal Health MD, and medical services provided to me by the Treating Physician are not covered or reimbursed by Medicare or other insurance. In consideration of Optimal Health MD undertaking to render me administrative or any other services relating in any way to this Agreement, or Optimal Health MD disclosing information or methods of treatment to me (either of which are deemed sufficient consideration for this agreement), then, in the event any court determines that I sought medical treatment or medical prescription through Optimal Health MD for the possible or apparent purpose, directly or indirectly, of deception, assisting any investigation, or the rendering of any type of assistance to, or disclosing any information pertaining to Optimal Health MD, its procedures or medical protocols, to any news organization, possible or actual competitor, any type of governmental agency, any investigator or any other company for the possible or apparent purpose of securing information, confidential or otherwise, about Optimal Health MD, I knowingly, expressly and irrevocably consents to a judgment in favor of Optimal Health MD or any party proceeding under the authority of this Agreement, of liquidated damages in the amount of Ten Million and No/Dollars ($10,000,000.00), which liquidated damage amount is hereby accepted by me as a reasonable amount for engaging in any such acts or deception and because damages are difficult to ascertain.

I am a competent adult at least 30 years of age. I am permitted by law in my state of residence to receive the medication(s) I am requesting for my personal medical and therapeutic purposes. I have been fully informed by appropriately trained health care personnel and understand the risks, benefits, and possible side effects of the prescription drug(s) I may request. I am requesting the prescription medication(s) solely for my own personal therapeutic and medical needs, and will not distribute any of the medication to others. In addition to my other duties hereunder, I will promptly contact a local physician for any necessary medical intervention should a complication or concern result related to the use of a requested medication. I realize there are risks as well as benefits to any medication, even over-the-counter drugs. I have been fully informed of the possible effects, risks, and benefits of this medication.

I agree to pay all reasonable attorneys fees and costs incurred by Optimal Health MD or a Medical Provider seeking to enforce this agreement. This agreement represents the complete and entire agreement between the parties to it.

Date: _____

Patient Signature

Witness Signature

Patient Printed Name _____

Witness Printed Name _____

_____

_____

OPTIMAL HEALTH MD
AGE MANAGEMENT CENTERS

# PHYSICAL EXAMINATION FORM

**THIS FORM MAY ONLY BE COMPLETED BY THE PHYSICIAN PERFORMING THE PHYSICAL EXAMINATION**

**Patient Name:** _____ **Date:** _____

**Date of Birth:** ____ /____ /_____ **Age:** _____ **Height:** _____ **Weight:** _____

**Blood Pressure:** _____ **Pulse:** _____ **Temp:** _____

**Please list any:**

**Medications:**

**Allergies:**

**Medical and Surgical Hx:**

**ROS (review of symptoms)** Please document any abnormalities**:**

| | | |
|---|---|---|
| HEENT: ..... | ☐ Normal | ☐ Abnormal |
| CARDIOVASCULAR: ..... | ☐ Normal | ☐ Abnormal |
| RESPIRATORY: ..... | ☐ Normal | ☐ Abnormal |
| GASTROINTESTINAL: ..... | ☐ Normal | ☐ Abnormal |
| GENITOURINARY: ..... | ☐ Normal | ☐ Abnormal |
| BREAST EXAM: ..... | ☐ Normal | ☐ Abnormal (if required) |
| PROSTATE EXAM: ..... | ☐ Normal | ☐ Abnormal (if required) |
| MUSCULOSKELETAL: ..... | ☐ Normal | ☐ Abnormal |
| SKIN: ..... | ☐ Normal | ☐ Abnormal |
| NEUROLOGICAL: ..... | ☐ Normal | ☐ Abnormal |

COMMENTS: _____

_____

**THIS FORM MAY ONLY BE SIGNED BY THE PHYSICIAN PERFORMING THE PHYSICAL EXAMINATION**

**Physician signature:** _____ **Date:** _____

**Physicians name:** _____

By signing, I acknowledge that I have examined the patient and refer him/her to Dr. George Safirstein, MD at Optimal Health MD, llc. I understand that, upon referral, Optimal Health MD, LLC. Assumes full responsibility for the patient as it pertains to the care that they provide.

**Please FAX Completed Form to: (954) 404-6819**

**Optimal Health MD, LLC. • 1250 E. Hallandale Beach Blvd, Suite 505 • Hallandale Beach, FL 33009**

## MAIL ORDER/PATIENT AGREEMENT FOR PURCHASE OF PRESCRIBED DRUGS LABORATORY TEST AND PHYSICIAN SERVICES

**Patient Agreement and Mail Order Purchase Instructions:**

1. Fax copy of the completed Mail Order Forms including Signature Page to: (954) 404-6819
2. Fax copy of completed Medical History Form to: (954) 404-6819
3. Fax copy of signed Authorization for Medical Care and Treatment to: (954) 404-6819
4. Send payment as instructed on the enclosed forms for wire transfers or pay by credit card.
5. Fax copy of your completed wire transfer instructions or credit card form to (954) 404-6819 If you elect to pay by wire transfer, the original wire transfer form must be delivered to your bank so that the bank can send the wire transfer of funds from your account to our office.
6. Phone our office after you have made the wire transfer or credit card payment to us and arrange for a physical exam and lab work (unless you can provide valid lab work by U.S Clinic or lab, lab work may not be required for your specific prescription.)
7. If you purchase a blood test or treatment, a licensed medical doctor will review your medical records and any lab work results for the purpose of issuing a prescription.
8. You have the option to purchase only the blood test and physician services and wait to be advised as to whether your requested prescription have been issued by a reviewing medical doctor.
9. If you purchased and receive physician services, lab work, and a medical program, (growth hormone or testosterone) then 100% of your funds shall be returned if your sought prescription is not granted after our receipt of your blood test results.
10. Purchaser understands and agrees that no purchase funds for any purchased medical program shall be returned to any purchaser after the prescription has been granted once we are in receipt of payment for any reason.
11. Please allow up to 3 business days for express overnight delivery after our receipt of your prescription.
12. Seller makes no claims to purchaser, or seller's agents, as to any benefits to be obtained by a specific individual with respect to pharmaceuticals prescribed or purchased from our affiliated organizations or Optimal Health MD, LLC.
13. Delivery is guaranteed to U.S. purchasers. Foreign purchasers are responsible for clearing customs in their own country with respect to their prescription purchase. Delivery of growth hormone is guaranteed to purchasers in the U. S.
14. U.S. pharmacies may dispense directly to purchaser pursuant to a prescription of a U.S. physician prescribed U.S. approved drugs purchased through Optimal Health MD, LLC. or our affiliated organizations.
15. Testosterone shall be dispensed directly to patient by a U.S. pharmacy pursuant to a prescription of a U.S. physician based on medical evaluation, patient medical history, diagnostic exam and current laboratory blood test.
16. Human Growth Hormone (HGH) is prescribed in the U.S. for disease and recognized medical conditions. Human Growth Hormone (HGH) shall be dispensed directly to patient by a U.S. pharmacy pursuant to a prescription of a U.S. physician based on medical evaluation, patient medical history, diagnostic exam and current laboratory blood test.

**Please PRINT Your Name:** _____

**Please SIGN Your Name:** _____ **Date:** _____

Signature of Purchasing Patient Required

# CREDIT CARD AUTHORIZATION FORM

## CREDIT CARD PAYMENT AUTHORIZATION FORM

**Date:** _____
Month / Day / Year

**Amount Purchased:** . . . . . **$** _____

**Add 5% of Purchased Amount for Shipping and Insurance:** . . **$** _____

**Total Including Insurance and Shipping 5% fee:** . . . **$** _____

**Credit Card Type:** ☐ **Visa** ☐ **Master Card** ☐ **Discover** **Amex**

**Credit Card Number:** | | | | | | | | | | | | | | | | |

**Credit Card Expiration Date:** _____ _____
Month / Year Security Code

(AMEX: 4 Numbers above the creditcard number)
(VISA: 3 Numbers after the creditcard number on the back of the card.

**Drivers License Number:** | | | | | | | | | | | | | | | | |

**Name:** _____
Please Sign of Your Name

**Name:** _____
Please Print Your Name

**BILLING ADDRESS:** ( NO P.O BOX NUMBERS )

_____

_____

City: _____ State: ____ Zip _____

Telephone Home: ( ) _____

Telephone Work: ( ) _____

**SHIPPING ADDRESS:** (IF DIFFERENT FROM BILLING) ( NO P.O BOX NUMBERS )

_____

_____

City: _____ State: ____ Zip _____

Telephone Home: ( ) _____

Telephone Work: ( ) _____

I hereby authorize Optimal Health MD, LLC. - its officers, agents, managers, unit holders, affiliates, employees, contractors and representatives to charge my credit card for the the stated U.S. dollar amount effective this date. Purchaser agrees that no credit card payment transaction shall be disputed by purchaser for any reason after the patient's has been provided and/or received products and services and payment transaction has occurred. Optimal Health and Rejuvenations Center, it's affiliates and/or service providers are not obligated to return any funds paid by the purchser(s) credit company for any reason. Optimal Health MD,LLC. reserves the right to refund or deny any payment at the companies sole discretion. Patient irrevocably waives any right to dispute any credit card charge(s).

## BANK WIRE TRANSFER AUTHORIZATION FORM

**Date:** _____
Month / Day / Year

**Amount Purchased: .....$** _____

**Add 5% of Purchased Amount for Shipping and Insurance: .....$** _____

**Total Including Insurance and Shipping 5% fee: .....$** _____

Bank Wire Information:

Bank of America
1900 Tyler Street
Hollywood, FL 33020

Optimal Health MD
1250 E. Hallandale Beach Blvd - Suite 505
Hallandale Beach, FL 33019

Routing number: #063000047
Bank Account: #898018882862

**Transaction Confirmation Receipt:** _____

**Name:** _____
Please Sign Your Name

**Name:** _____
Please Print Your Name

Phone Number: Home (____) _____

Work (____) _____

Purchaser agrees that no wire transfer payment transaction shall be disputed by purchaser for any reason after the wire transfer payment transaction has occurred and that patient shall not be entitled to a return of any purchase funds paid by credit card for any reason. Patient irrevocably waives any right to dispute charge.

# BANK DIRECT DEPOSIT FORM

## BANK PAYMENT AUTHORIZATION

**"DIRECT" DEPOSIT INFORMATION:**

**Bank of America**
**1900 Tyler Street**
**Hollywood, FL 33020**

**Optimal Health MD**
**1250 E. Hallandale Beach Blvd**
**Suite 505**
**Hallandale, FL 33009**

**Routing number #063000047**
**Bank Account #898018882862**

**Transaction Receipt:** _____

**Name:** _____
Please Sign Your Name

**Name:** _____
Please Print Your Name

**Phone Number:** Home (  ) _____ Work (  ) _____

Purchaser agrees that no bank deposit and/or wire transfer payment transaction shall be disputed by purchaser for any reason after the wire transfer payment transaction has occurred and that patient shall not be entitled to a return of any purchase funds paid by credit card for any reason. Patient irrevocably waives any right to dispute charge.