Patient Intake Form

Please complete all sections. Print clearly in black or blue ink.

Personal Information

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Email Address: _____

Street Address: _____

City: _____ State: _____

ZIP Code: _____

Treatment State

State where you will receive treatment: _____

Treatment Selection (Check all that apply)

Select the treatment(s) you are interested in:

Weight Loss:

- [ ] Semaglutide (Ozempic/Wegovy) - Weekly injection for weight management
- [ ] Tirzepatide (Mounjaro/Zepbound) - Weekly injection targeting GLP-1 and GIP receptors

Cellular Health:

- [ ] NAD+ Injections - Cellular energy and longevity support
- [ ] Semax/Selank Peptides - Cognitive enhancement and stress reduction

Energy & Vitality:

- [ ] Glutathione Treatment - Master antioxidant for cellular protection
- [ ] Lipo+B12 Shot - Enhanced metabolism and energy support
- [ ] AOD-9604 Peptide - Fat metabolism and body composition
- [ ] MOTS-C Peptide - Mitochondrial energy and metabolic optimization
- [ ] BPC 157/TB 500 - Recovery and tissue repair support

Health Information

Height (ft/in):

Weight (lbs):

Sex:

- [ ] Male
- [ ] Female

Please answer the following health questions:

Are you currently pregnant or breastfeeding?

- [ ] Yes, pregnant
- [ ] Yes, breastfeeding
- [ ] No
- [ ] Not applicable

Do you have a current or past history of cancer?

- [ ] Yes, currently being treated
- [ ] Yes, in the past (now in remission)
- [ ] No

Are you currently taking any medications?

- [ ] Yes (please list below)
- [ ] No

Current medications:

Do you have any known drug allergies?

- [ ] Yes (please list below)
- [ ] No
- [ ] Not sure

Known allergies:

Medication Consent

Informed Consent for GLP-1 Medication

I understand that I am being prescribed a GLP-1 receptor agonist medication for weight management. I acknowledge that:

- This medication is administered via subcutaneous injection.
- Common side effects may include nausea, vomiting, diarrhea, constipation, and abdominal pain.
- Serious but rare side effects may include pancreatitis, gallbladder disease, and thyroid tumors.
- I will follow the dosing instructions provided by my healthcare provider.
- I will report any adverse reactions or concerns to my healthcare team immediately.
- I understand that results may vary and this medication is part of a comprehensive weight management program.
- I should not use this medication if I have a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).
- I should not use this medication if I am pregnant, planning to become pregnant, or breastfeeding.
- I understand that I need to inform my healthcare provider of all medications I am currently taking, including over-the-counter medications and supplements.
- I understand that alcohol consumption may increase the risk of low blood sugar (hypoglycemia) and should be limited while on this medication.

I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily consent to receive this treatment.

☐ I have read, understand, and agree to the medication consent above

Peptide Therapy Acknowledgment

I understand that peptide therapies offered by this clinic are research-based, may be prescribed off-label, and are not FDA-approved for the indications discussed. I acknowledge that benefits are not guaranteed and that I have had the opportunity to ask questions. I agree to notify the clinic of any adverse reactions and to follow all clinical guidance provided.

☐ I have read, understand, and agree to the Peptide Therapy Acknowledgment above

Patient Signature: _____ Date: _____

Printed Name: _____

Telehealth Consent

Consent for Telehealth Services

I hereby consent to receive healthcare services via telehealth technologies. I understand that:

- Telehealth involves the use of electronic communications to enable healthcare providers to share individual patient medical information for the purpose of improving patient care.
- The information may be used for diagnosis, therapy, follow-up, and/or patient education.
- My healthcare provider may use video, audio, and other telecommunications technology.
- Technical difficulties may occur before or during the telehealth session and I may need to reschedule if connection issues prevent effective communication.
- I have the right to withhold or withdraw my consent at any time without affecting my right to future care or treatment.
- I understand that telehealth services are not a substitute for emergency care. If I experience a medical emergency, I should call 911 or go to the nearest emergency room.
- I am responsible for maintaining the confidentiality of my telehealth session on my end, including ensuring I am in a private location.
- The laws that protect the privacy and confidentiality of medical information also apply to telehealth.
- I understand that my healthcare provider may determine that telehealth is not appropriate for my condition and may recommend an in-person visit.
- I may be responsible for applicable copays, deductibles, and coinsurance for telehealth services as outlined by my insurance plan.
- I understand that my telehealth session may be recorded for quality assurance purposes, and I will be informed if recording is taking place.

I have read and understand the information provided above regarding telehealth. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

☐ I have read, understand, and agree to the telehealth consent above

Patient Signature: _____ Date: _____

Printed Name: _____

HIPAA Authorization & Privacy Notice

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.

Uses and Disclosures of Protected Health Information (PHI):

- Treatment: We may use your PHI to provide, coordinate, or manage your healthcare and related services.
- Payment: We may use and disclose your PHI to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your PHI for quality assessment and training programs.
- Required by Law: We may use or disclose your PHI when required by federal, state, or local law.
- Public Health Activities: We may disclose your PHI for public health activities and reporting.

Your Rights Regarding Your PHI:

- Right to Access: You have the right to inspect and obtain a copy of your PHI that we maintain.
- Right to Amend: You may request an amendment to your PHI if you believe it is incorrect or incomplete.
- Right to Accounting: You have the right to receive an accounting of certain disclosures of your PHI.
- Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your PHI.
- Right to Confidential Communications: You may request we communicate with you in a certain way or location.
- Right to a Paper Copy: You have the right to obtain a paper copy of this notice upon request.

Our Responsibilities:

- We are required by law to maintain the privacy of your PHI and provide you with this notice.
- We will not use or disclose your PHI without your written authorization, except as described herein.
- We reserve the right to change our privacy practices and make new provisions effective for all PHI we maintain.

By signing below, I acknowledge that I have received a copy of TruCare Health's Notice of Privacy Practices and understand how my protected health information may be used and disclosed.

☐ I acknowledge receipt of the Notice of Privacy Practices

☐ I authorize TruCare Health to use and disclose my PHI as described above

Patient Signature: _____ Date: _____

Printed Name: _____

ID Verification

Please attach a copy of your government-issued ID (Driver's License, State ID, Passport, or Military ID).

ID Type:

- ☐ Driver's License
- ☐ State ID
- ☐ Passport
- ☐ Military ID

☐ I confirm that the ID document attached is mine and is current and valid.

For Office Use Only

Date Received: _____ Received By: _____

Reviewed By: _____ Review Date: _____

Notes: _____

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