New Patient Intake Form

Name_____ Date of Birth_____

Address_____
(Street/apt) (City) (State) (Zip code)

Cell Phone: _____ Email:_____
I consent to the email address being used for appointment reminders as well as added to the Priority You MD email newsletter, where I will get information on specials and promotions

Driver License Number: _____

Single/Married/Widowed/Divorced Advanced Directive Y/N Living Will: Y/N Power of Attorney: Y/N

How did you hear about us? _____

Employer _____ Occupation _____

Person to contact in case of an emergency _____Phone _____

Pharmacy Preference _____ Phone ( ) _____

I request that medical information, test results, or messages:
(INITIAL below all that apply)
_____ be given only to me directly in person or over the phone
_____ be left on my home/cell answering machine/voice mail
_____ be left with a member of my household. Name_____
_____ be mailed to my mailing address listed above
_____* be emailed to me at _____
* I understand that email is not secure and may be intercepted by unauthorized people and possibly made available on the internet. Understanding this possibility and that you have advised me that you would prefer to send my confidential information by mail, I still request that you email me the confidential information to the above email address.

I consent to medical treatment. I agree to pay all charges for myself, and for members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

_____ _____
Patient/ Parent/Guardian Signature Date

PAST MEDICAL HISTORY

Previous or current primary care physician (PCP): _____

Date of last physical examination or visit to PCP: _____

Past/ Current Medical Conditions:

_____

_____

_____

Medication **ALLERGIES**: _____

Medications (please include dosages):

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Over-the-counter medications taken at least once weekly: _____

Herbal products, supplements, vitamins or minerals: _____

_____

PREVENTATIVE CARE

Last colonoscopy: _____ Last chest x-ray: _____ __ Last testicular exam: _____

Last EKG: _____ Last mammogram: _____ Last pap smear: _____

Last breast exam: _____ Last bone scan: _____Last prostate exam and PSA: _____

SOCIAL HISTORY:

Do you smoke? Y/N How much? _____ packs/day How many years have you smoked? _____

High, medium, or low nicotine content? _____ If you quit, what year(s)? _____

Do you drink alcohol? Y/N How much and how often?: beer_____ wine _____ liquor_____

Subjective Symptom Assessment

Physical Symptoms	Score	Mental Health Symptoms	Score
How satisfied with you with your **body**?		How would you rate your overall **mood**?	
How satisfied are you with your **weight**?		How would you rate your response to **stress?**	
How satisfied are you with your **sleep quality**?		How would you rate your ability to **manage stress?**	
How satisfied are you with your overall **strength**?		Rate your level of **Anxiety**	
How satisfied are you with your overall **health**?		Rate your level of feeling **depressed**	
How satisfied are you with your **exercise regimen**?		How would you rate your **job satisfaction?**	
How satisfied are you with your **energy level**?		Are you satisfied with **OTHERS perception** of you?	
How satisfied are you with your **libido**?		How satisfied are you with completing **tasks**?	
How satisfied are you with your **sexual performance**?		How satisfied are you with your **memory**?	
		How satisfied are you with your **self-confidence**?	
		How satisfied are you with your current **life**? (current day to day activities)	
		How satisfied are you with your **future plan**?	
Total Physical Score:		**Total Mental Health Score:**	
Total Wellness Score: **(Physical + Mental Health Score)**			

Severity	Score
Poor/ None	1
Could be better	2
Average	3
Content	4
Excellent/Very Happy	5

Consent for Medical Treatment, Hormone & Peptide Therapy, and

Use of Compounded Medications (Page 1 of 2)

1. Consent to Medical Evaluation and Treatment

- I consent to receive medical evaluation and treatment from Priority You MD and its medical providers. I understand that treatment plans may include prescription medications, lifestyle recommendations, lab monitoring, and follow-up visits.

2. Telehealth Follow-Up Authorization

- I understand that follow-up visits may be conducted in person or via telehealth when appropriate and agreed upon. I understand that: My provider will determine whether telehealth is clinically appropriate; I may ask to be seen in person at any time.

3. Compounded Medication Disclosure

- I understand that Priority You MD may prescribe compounded medications prepared by a licensed compounding pharmacy. I acknowledge:
  - Compounded medications are custom formulations and may not be FDA-approved.
  - Potency, sterility, and effectiveness may vary between pharmacies.
  - These medications cannot be returned or refunded once dispensed.
  - I have been informed of the risks, benefits, and alternatives.

4. Off-Label Use Disclosure

- I understand that certain therapies I may receive, including hormone replacement therapy, peptide therapy, and GLP-1 medications (Semaglutide/Tirzepatide) may be used "off-label," meaning for purposes not specifically approved by the FDA. I acknowledge that my provider has determined these treatments are appropriate for my health goals and symptoms.

5. Hormone Optimization Therapy Risks

- If I receive hormone therapy (such as testosterone, estrogen, progesterone, DHEA, pregnenolone, or thyroid medication), I understand the possible risks may include but are not limited to:

  • Increased hematocrit / blood thickness, Fluid retention, mood changes, acne, hair changes, Breast tenderness, menstrual changes, Fertility changes, Possible impact on cholesterol or liver enzymes

- I agree to follow recommended lab monitoring and follow-up evaluations.

6. Peptide Therapy & GLP-1 Medication Risks

- If I receive peptide therapy or GLP-1-based medications (Semaglutide/Tirzepatide), I understand risks may include:

  • Injection site irritation or bruising, Nausea, constipation, vomiting or diarrhea, Headache or fatigue, changes in appetite or body weight, Rare risks such as allergic reaction or pancreatitis

- I agree not to adjust my dose without provider instruction.

Consent for Medical Treatment, Hormone & Peptide Therapy, and

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7. Wellness Injection Therapies

- If I receive wellness injectables (NAD+, Glutathione, Vitamins, etc.), I understand potential risks include:

  • Mild injection discomfort, Headache, nausea, or allergic reaction

8. Lab Monitoring & Follow-Up Responsibility

- I understand that:
  - Lab testing is required at intervals determined by my provider

  • I am responsible for completing labs in a timely manner

  • I must attend follow-up visits to continue receiving prescriptions

- Failure to complete required monitoring may result in treatment being paused.

9. No Guarantee of Results

- I understand that results vary based on individual biology and adherence to treatment recommendations. No guarantee of specific results has been made.

10. Medication & Financial Policy

- I understand:

  • Compounded medications and injections are not returnable or refundable.

  • Payment for services and medications is due at the time of service.

  • If I discontinue treatment, no refunds are issued for services already rendered or medications already dispensed.

By signing below, I confirm that:

• I have read and understand both pages of this consent form.

• I have had the opportunity to ask questions.

• I voluntarily agree to proceed with evaluation and treatment.

Patient Signature: _____ Date: _____

Print Name: _____ Birthdate: _____

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can gain access to this information. Please review this notice carefully.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – ie: ordering diagnostic tests or consultations
- Payment – ie: submitting bills to your insurance company
- Health Care Operations – ie: quality assurance and eligibility verification

We may also use your medical information for emergency treatment when we attempt to obtain consent and are unable to do so, and consent for treatment is implied under the circumstances.

You Have a Right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any requested restriction
- Receive confidential communications from us, upon written request
- Inspect and request copies of your medical information, upon written request
- Request to amend incorrect or incomplete medical information, upon written request
- Receive an accounting of any disclosures made, upon written request

We are Responsible for:

- Maintaining the privacy of your medical information
- Abiding by the terms of this notice
- Providing written notice of any change to this notice

Authorizations: Upon your written authorization (verbal or implied in the event of an emergency), we may disclose your medical information to a requesting entity, such as another provider, relative, or an attorney. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient Contact: We may contact you by telephone, SMS text, mail, or e-mail to provide such information as appointment reminders, treatment information or any other necessary communications.

Complaints: You may complain to us or to the Department of Health and Human Services if you believe that your privacy has been violated. If you wish to complain to us, please provide the Office Manager with written notice if you believe your privacy has been violated. All notices received will be investigated and reviewed by a Compliance Officer. You will receive a response to any notice within two weeks. To Obtain Information: Contact our Office Manager at 727-230-1438

I have received and reviewed a copy of the "Notice of Privacy Practices" Statement from Priority You MD.

_____ _____

Signature Date

Medical Records Release Authorization Form

Release Records From:

Physician/Facility: _____

Address: _____
_____

Phone #: _____

Fax #: _____

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Authorization Expires: _____

Information to be Disclosed:
___ All Records ___Imaging ___Labs ___EKG ___Other: _____

Purpose for Disclosure: _____

Release Records to:

Priority You
2744 Summerdale Drive
Clearwater, FL 33761
Fax to: (727) 230-1437

Authorization: I certify that this request has been made freely and voluntarily and that the information given above is accurate and complete to the best of my knowledge. I understand that I have the right to receive a copy of this form after I sign it. I may revoke this authorization in writing at any time except to the extent that action has already been taken comply with it. Written revocation is effective upon receipt at our facility.

Patient Signature: _____ Date: _____