



Peptide 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

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 _____



Consent for Medical Treatment, Peptide Therapy, GLP-1 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 peptide therapy, GLP-1 therapy for weight management or metabolic improvement, lifestyle recommendations, 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.

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 redness, irritation, or bruising
 - Nausea, constipation, diarrhea, or vomiting
 - Headache or fatigue
 - Appetite or weight changes
 - Rare but serious risks: allergic reaction, pancreatitis, gallbladder disease, or low blood sugar (especially when combined with certain diabetes medications)
 - **I agree not to change my dose without provider instruction.**

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

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.



Consent for Medical Treatment, Peptide Therapy, GLP-1 Therapy and
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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