TWIN PORTS WELLNESS + AESTHETICS

Look Better, Feel Better, Live Better

1728 Tower Ave
Superior WI 54880
(715)395-0928
twinportshealth.com

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WELLNESS +
AESTHETICS

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Your Health, Our Priority

At our health care clinic we want to provide the best care possible to our patients. We are always actively looking for ways to make our patients more comfortable, happier and live their lives to the fullest.

Our team of qualified medical providers have over 20 years of experience over a wide range of subjects. Your health is our biggest priority so we are constantly researching new methods to provide you with better care.

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PATIENT INTAKE FORM

Name ______________________ Date ______________

Date of Birth ______________ Age ________ Gender ________

Address ______________________________________

City ______________ State ________ Zip Code ____________

Email Address ______________________ Phone No ______________

Emergency Contact ______________________ Phone No ______________

How did you hear about us? ______________________________

Do you consent to receive labs and other information via email (unsecured, not HIPPA protected)? ☐ Yes ☐ No

MEDICAL HISTORY

Are you allergic to any of the following? ☐ GLP-1 Receptor Agonists ☐ Sodium Phosphate

☐ Adhesives/latex ☐ Lidocain/xylocain ☐ Iodine/Betadine ☐ Benzoin

Other allergens: ☐ No ☐ Yes: If yes, please list allergen and reaction:

____

Are you currently taking blood thinners (i.e., Aspirin/Warfarin), Bexarotene, Gatifloxacin, or any Diabetes medication (i.e. Insulin or sulfonylureas)? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Type(s): ______________________________________

Date of last Mammogram? ☐ Abnormal Findings or Follow up? ☐ No ☐ Yes:

____

Have you had a colonoscopy? ☐ No ☐ Yes: Date of last colonoscopy? ☐

Abnormal Findings or Follow up?

____

Have you had surgery in the past year? ☐ No ☐ Yes: ______________________

____

Have you or a family member been diagnosed with either of the following? ☐ No ☐ Yes:

☐ Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2) ☐ Medullary Thyroid Carcinoma

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PATIENT INTAKE FORM

MEDICAL HISTORY

Please select any relevant conditions below:

- ☐ Adrenal disorder
- ☐ Alopecia (hair loss)
- ☐ Anemia
- ☐ Angina
- ☐ Angioedema
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disease
- ☐ Breast Cancer
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ COPD chronic obstructive pulmonary disease
- ☐ Deep vein thrombosis (DVT)
- ☐ Depression/Anxiety
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy/seizures
- ☐ Endocarditis
- ☐ Gastric/duodenum ulcer
- ☐ Heart failure/valve disease
- ☐ Hemochromatosis
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hypotension (low BP)
- ☐ Hypertension (elevated BP)
- ☐ Hyperthyroidism overactive thyroid
- ☐ Hypothyroidism underactive thyroid
- ☐ IBD/IBS
- ☐ Kidney disease
- ☐ Lupus
- ☐ Liver Disease: what type(s):
- ☐ MI / Heart Attack
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parathyroid disorder
- ☐ PCOS
- ☐ Psychiatric Disorder
- ☐ Pulmonary Embolism
- ☐ Renal failure
- ☐ Sleep Apnea
- ☐ Suicidal Ideation
- ☐ Substance abuse
- ☐ Stroke

Details or any other condition:

____

____

FEMALE MEDICAL HISTORY

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-menopause

☐ Using contraceptives: ____________________ ☐ Other: ____________________

Date last menses: ________ Pregnancies: ________ Live births: ________

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes How many per day? ______ How long? ______

Do you drink alcohol on a regular basis? ☐ No ☐ Yes Weekly units: ______

Activity level? ☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active

Do you drink caffeine? ☐ Yes ☐ No How much per day?: ______

Date of last physical: ______ Primary Care Provider: ______

Relevant results:

GENERAL MOOD AND FEELINGS

Check the answer that best describes your feeling:

I have little interest or take little prleasure in doing things.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

I feel down, depressed, and hopeless.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

I have trouble falling or staying asleep.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

Family medical history:

☐ Heart Disease ☐ Osteoporosis ☐ Breast Cancer

☐ Diabetes ☐ Alzheimer's/dementia ☐ Other:

Activity Level:

☐ low ☐ moderate ☐ average ☐ high

Marital Status:

☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Living with Partner

Sexual Health:

☐ I'm sexually active ☐ My sex life has suffered. ☐ I want to be sexually active.

☐ I have difficulty achieving organism ☐ I do not want to be sexually active.

Female Medical History

Have you completed your family?: ☐ Yes ☐ No

Date last menses: ______ Pregnancies: ______ Live births: ______

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-menopause

Are you sexually active? ☐ Yes ☐ No Do you have issues with low sex drive?: ☐ Yes ☐ No

Currently using contraceptives?: ☐ Yes ☐ No Contraceptive Name: ______

Birth control method?: Check below or specify type/method: ______

☐ Menopause ☐ Hysterectomy ☐ Birth Control Pills ☐ Condoms

☐ IUD ☐ Tubal Ligation ☐ Vasectomy ☐ Infertility

☐ Other: ______

Dates & other info (i.e. initiation of pills, IUD placement, ablation, menopause, ect.):

______

Please select any relevant conditions below:

☐ Uterine Cancer
☐ Uterine fibroids
☐ Endometriosis
☐ Irregular heavy periods
☐ Ophorectomy (removal of ovaries only)
☐ Breast Cancer
☐ History of seizure/epilepsy

☐ Hysterectomy (total) ovaries & uterus
☐ Hysterectomy (partial)Uterus only
☐ Menstral Migraines
☐ Ovarian Cancer
☐ Polycystic Ovaries /PCOS
☐ Painful periods
☐ Irregular periods

☐ Uterine Ablation (when/why?)
☐ Loss of Scalp Hair
☐ Hot Flashes
☐ Breast Cancer
☐ Water weight
☐ Fibromyalgia
☐ Heavy Cycles

Do you take hormones of any kind? ☐ No ☐ Yes: if so, list (include birth control, HRT, natural hormones):

______

______

Past BHRT pellet Therapy? ☐ No ☐ Yes: Date/Dose of last pellets?

______

______

Male Medical History

Have you completed your family?: ☐ Yes ☐ No Are you sexually active? ☐ Yes ☐ No

☐ I want to be sexually active?

Erectile function (select any relevant symptoms)

- ☐ Trouble getting an erection during sex?
- ☐ Erections not hard enough for penetration?
- ☐ Trouble maintaining erection during sex
- ☐ Lack of sexual satisfaction from sex

Low Testosterone (select any relevant symptoms):

- ☐ low sex drive
- ☐ lost height
- ☐ low energy
- ☐ decreased strength
- ☐ sleep disturbance
- ☐ less strong erections
- ☐ sad or grumpy
- ☐ decreased endurance
- ☐ hot flashes or night sweats

Other:

Please list any specific concerns and questions you want to discuss with provider:

Please select any relevant conditions below:

- ☐ BPH (prostate enlargement)
- ☐ Painful urination
- ☐ cloudy, bloody urine
- ☐ urinating too often
- ☐ trouble passing urine
- ☐ loss of urine (incontinence)
- ☐ taking medicine for prostate
- ☐ sleep apnea
- ☐ had a sleep study: (normal / abnormal)
- ☐ elevated PSA
- ☐ Hair loss
- ☐ Vasectomy
- ☐ History of anemia
- ☐ taking medication for male pattern balding
- ☐ erectile dysfunction
- ☐ testicular or prostate cancer
- ☐ kidney disease or decreased function
- ☐ frequent blood donations
- ☐ non-cancerous testicular lesions
- ☐ severe snoring
- ☐ I wish to have children in the future

Current hormone replacement? ☐ No ☐ Yes: if so, list (all modalities, TRT, HRT, natural hormones):

Past Hormone Therapy? ☐ No ☐ Yes:

Last Pellet therapy? ☐ No ☐ Yes: Date/Dose of last pellets?

WEIGHT HISTORY

Height: ______ **Current Weight:** ______ **BMI:** ______

How old were you when you first became more than 20 lbs overweight? ______

Were you overweight as a child? ☐ No ☐ Yes

What was your highest lifetime weight? ______ What was your Highschool weight? ______

What factors do you consider contribute to your experience of excess weight?

☐ Low energy ☐ Sedentary lifestyle ☐ Hormonal changes
☐ Medical condition ☐ Sleep disruptions ☐ Alcohol
☐ Pregnancy ☐ Stress/busy lifestyle ☐ Excess calories
☐ Perimenopause Other: ______ ☐ Family history

Have any of your close relatives been overweight or had obesity (check all that apply):

☐ Mother ☐ Father ☐ Siblings

Does your family support your efforts to have a healthier lifestyle? ☐ No ☐ Yes

Do you exercise regulary? ☐ No ☐ Yes What kid of exercise? ______

How many times per week? ______ How many minutes per session? ______

Do you work outside your home? ☐ No ☐ Yes: If yes what type of work? ______

During the last 3 months, did you have any episodes of excessive overeating?
(i.e., eating significantly more than what most people would east in a similar period of time)
☐ Yes ☐ No If yes, about how many times? ______

Do you sometimes make yourself vomit as a means to control your weight? ☐ Yes ☐ No

Have you ever been diagnosed with (check all that apply): ☐ Bulimia ☐ Anorexia ☐ Binge eating disorder ☐ No

Do you feel distressed about episodes of overeating? ☐ Yes ☐ No

Do you often feel like you have no control over your eating or cannot stop? ☐ Yes ☐ No

Are you often embarrassed by how much you eat? ☐ Yes ☐ No

Do you feel disgusted with yourself for overeating, or do you feel guilty for overindulging? ☐ Yes ☐ No

Do you avoid social interaction because of your weight? ☐ Yes ☐ No

Does being overweight cause you to feel depressed? ☐ Yes ☐ No

WEIGHT HISTORY

Have you ever been treated by a doctor for your weight? ☐ Yes ☐ No

When? ☐ Successful? ☐ Yes ☐ No How much weight did you loose? ☐

Have you participated in a weight loss program? ☐ Yes ☐ No

Please indicate which of the following weight loss programs you have tried:

☐ Jenny Craig ☐ Weight Watchers ☐ Diet ☐ Exercise ☐ Therapy

☐ Optavia ☐ Nutri-system ☐ Herbal Supplements ☐ Other:

Please indicate which of the following medications you have tried for weight loss:

☐ Phentermine ☐ Belviq (lorcaserin) ☐ Contrave(naltrexone/bupropion)

☐ Xenical (orlistat) ☐ Topamax (topiramate) ☐ Saxenda (liraglutide) for weightloss

☐ Other: ____________________ ☐ Victoza (liraglutide) for DM2

Have you ever consulted with a registered dietitian? ☐ Yes ☐ No

Have you ever had bariatric surgery? ☐ Yes ☐ No

Have you ever consulted a surgeon regarding bariatric surgery? ☐ Yes ☐ No

What are your main motivations and concerns for wanting to lose weight with a GLP-1 RA/GIP (Semaglutide/Tirzepatide) medication?

____

____

What is your goal Weight? Short term: ☐ Long term: ☐

How do you plan to achieve your weight loss goals? (action steps or lifestyle modification):

____

____

____

____

Please list any specific concerns or questions you want to discuss with provider:

____

____

____

____

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REVIEW OF SYSTEMS

Eyes

Question	Yes	No
Do you have glaucoma?	Yes	No
Do you have retinopathy? (diabetes-related eye disease)	Yes	No
Do you have blurry vision?	Yes	No

Neurologic

Question	Yes	No
Do you have tingling in your hands or feet?	Yes	No
Do you have hand tremor, or does your hand shake when you hold it out?	Yes	No
Have you ever had migraine headaches?	Yes	No
Do you take medication to prevent migraine headaches?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had a stroke or TIA (transient ischemic attack)?	Yes	No

Respiratory

Question	Yes	No
Do you snore?	Yes	No
Have you ever been diagnosed with sleep apnea?	Yes	No
Do you get short of breath when walking?	Yes	No
Do you wheeze?	Yes	No

Cardiac

Question	Yes	No
Have you been diagnosed with angina?	Yes	No
Have you ever had a heart attack?	Yes	No
Have you ever been diagnosed with an arrhythmia (irregular heartbeat)?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No
Do you get short of breath when lying down flat?	Yes	No
Do your feet swell?	Yes	No
Do you ever have palpitations? (racing heart)	Yes	No
Do you ever have chest pain?	Yes	No
Do you take medication for high cholesterol?	Yes	No
Do you take medication for high blood pressure?	Yes	No

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REVIEW OF SYSTEMS

Gastrointestinal

Question	Yes	No
Have you been diagnosed with GERD (gastroesophageal reflux disease?	Yes	No
Do you ever have heartburn?	Yes	No
Have you had gallstones?	Yes	No
Have you had your gallbladder removed (choleysystectomy)?	Yes	No
Have you ever been diagnosed with pancreatitis?	Yes	No
Do you have abdominal pain?	Yes	No
Have you had part of your intestine removed?	Yes	No
Have you been diagnosed with gastroparesis?	Yes	No
Do you frequently have diarrhea?	Yes	No
Do you frequently have nausea?	Yes	No
Do you vomit frequently?	Yes	No

Nephrology

Question	Yes	No
Do you have a history of kidney stones?	Yes	No
Do you have trouble holding your urine?	Yes	No
Do you experience excessive urination?	Yes	No
At night do you wake up to urinate?	Yes	No
Do you ever have blood in your urine?	Yes	No

Musculoskeletal

Question	Yes	No
Do you have a history of arthritis?	Yes	No
Do you have pain in your knees?	Yes	No
Do you have pain in your hips?	Yes	No
Do you have chronic back pain?	Yes	No
Do you have trouble walking or exercising due to joint pain?	Yes	No
Do you take medication for joint or back pain?	Yes	No
Have you had a joint replacement (ex. hip or knee surgery)?	Yes	No

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REVIEW OF SYSTEMS

Endocrine

Question	Yes	No
Have you been told that you have prediabetes?	Yes	No
Do you have dry mouth?	Yes	No
Do you have excessive thirst?	Yes	No
Are you planning to have children within the next year?	Yes	No
Have you been diagnosed with infertility or been told you're infertile?	Yes	No
Do you have low sex drive?	Yes	No

Woman

Question	Yes	No
Do you have acne?	Yes	No
Do you have increased facial hair?	Yes	No
Do you have irregular periods?	Yes	No
Do you have breast pain or have fibrocystic breast disease?	Yes	No

Men

Question	Yes	No
Have you been diagnosed with low testosterone (low-T)?	Yes	No
Have you been diagnosed with erectile dysfunction?	Yes	No

Psychiatric

Question	Yes	No
Have you been diagnosed with anxiety?	Yes	No
Have you been diagnosed with depression?	Yes	No
Have you ever been diagnosed with ADD/ADHD?	Yes	No
Have you ever been diagnosed with bipolar disorder?	Yes	No
Do you have trouble sleeping?	Yes	No
Do you drink more than 2 alcoholic beverages per day?	Yes	No
Do you take pain medication or opiates on a regular basis?	Yes	No
Do you have memory problems?	Yes	No
Do you take medication for depression or anxiety?	Yes	No

Please provide a list of all medications or supplements you take:

MEDICATION OR SUPPLEMENTS	DOSE	FREQUENCY	COMMENTS

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the practitioner of any changes to my medical history or skincare routine. I agree to waive all liabilities of the practitioner or employer for any injury or damages incurred due to misrepresentation of my health history.

Please note that if you contact our provider it may take up to 7-10 business days for her to get back to you for non emergency.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

C O N S E N T F O R M

Medical Weight loss Therapy (Semaglutide/Tirzepatide)

I consent to taking a GLP-1 RA (Semaglutide) or a GIP/GLP-1 RA(Tirzepatide) injection as prescribed by my healthcare provider. Semaglutide is a GLP-1 receptor agonist for diabetes management, with off-label usage for chronic weight management. Tirzepatide is a glucose-dependent insulinotropic polypeptide (GIP) receptor and GLP-1 receptor agonist for diabetes management, with off-label usage for chronic weight management. I have been informed of the correct administering method and dosage. I will not take this medication if I have a history of the following: (please initial each box in acknowledgement).

- ☐ You are pregnant or planning to conceive while using this medication.
- ☐ You have a personal or family history of Medullary Thyroid Carcinoma (Thyroid Cancer) or Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2).
- ☐ You have a history of pancreatitis, kidney failure/disease, liver failure/disease, digestive issues, or gastroparesis.
- ☐ You are allergic to Semaglutie/Tirzepatide or any GIP/GLP-1 R agonist medications (e.g., Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®), or you have other undisclosed allergies.
- ☐ You are diabetic, have retinopathy, or take medication to lower blood sugar without consulting your endocrinologist or Primary Care Provider.

Common side effects: nausea, diarrhea, decreased appetite, vomiting, constipation, abdominal pain, and indigestion.
Severe side effects: Contact your medical professional immediately if you experience the following:

- Severe stomach pain or changes.
- Eye and vision changes, including blurry vision.
- Symptoms of hypoglycemia (dizziness, headache, increased hunger, raised heart rate, sweating, anxiety, irritability, and confusion).
- Kidney problems, including decreased urination, swelling in the ankles or feet, shortness of breath, and increased tiredness.
- Gallbladder pain or changes, including symptoms of chalky stool, upper abdominal pain, nausea and vomiting, bloating, and heartburn.
- Signs of a thyroid tumor, with a lump or swelling in the neck, trouble swallowing, voice hoarseness, or shortness of breath. Contact your doctor immediately.

Stop the medication and seek immediate medical attention if you experience the following:

- Pancreatitis, with severe upper abdominal pain that radiates to the back, which may be accompanied by vomiting.
- Serious allergic reaction, with rash, itching, swelling of the face, tongue, or throat and trouble breathing.

TwinPortsHealth@yahoo.com 715-395-0928 TwinPortsHealth.com

CONSENT FORM

Medical Weight loss Therapy (Semaglutide/Tirzepatide)

Possible drug interactions: anti-diabetic agents (i.e., Insulin and Sulfonylureas) can lead to an increased risk of hypoglycemia (low blood sugar). Gatifloxacin also increases the risk of hypoglycemia. Inform your provider of any medications that may lower blood sugar. Do not combine with other GLP-1-RA or GIP/GLP-1 RA medicines (i.e., Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®, Semaglutide, Tirzepatide). Bexarotene increases the risk of pancreatitis and should not be taken alongside Semaglutide or Tirzepatide.

Black Box Warning:
Semaglutide/Tirzepatide may cause thyroid tumors, as well as the following serious side effects: pancreatitis, hypoglycemia (low blood sugar), kidney problems, severe stomach pain and problems, changes in vision, gallbladder pain and issues, as well as allergic reactions.
If you take birth control pills, they may not work as effectively while taking Semaglutide/Tirzepatide. Discuss this with your healthcare provider to discuss the most appropriate options.

I acknowledge that Semaglutide/Tirzepatide is one part of a comprehensive lifestyle approach that includes a healthy diet and exercise, and regular follow-up visits to adjust dosages are necessary.

By signing below, I confirm that I have been fully informed of the potential risks, benefits, and complications and voluntarily agree to take this medication. I have had the opportunity to ask questions, and all my concerns have been taken care of to my satisfaction. I release Twin Ports Wellness and Aesthetics and the medical providers employed from any liability or claims arising from the treatment.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

F A Q ' S

Semaglutide/Tirzepatide

WHAT IS A GIP/GLP-1 R AGONIST AND HOW CAN IT HELP WEIGHT LOSS?

Semaglutide is a GLP-1 receptor agonis. Terzepitde is a GIP and GLP-1 receptor agonist. When administered as an injection, it helps regulate appetite and food intake. The medication can assist adults with obesity or those who are overweight in their weight management journey.

HOW DO I TAKE SEMAGLUTIDE/TIRZEPATIDE INJECTIONS?

Semaglutide or Tirzepatide is usually injected once a week. It comes in a pre-filled pen or syringe, and you can administer the injection under the skin of your stomach, thigh, or upper arm. Your healthcare provider will guide you on the proper technique.

HOW LONG DOES IT TAKE FOR SEMAGLUTIDE/TIRZEPATIDE TO WORK?

GIPs/GLP-1 R Agonists may start to show noticeable effects on weight loss within a few weeks of regular use. However, individual responses may vary. It's essential to stay committed to healthy eating habits and physical activity, to achieve the best and sustainable weight loss results.

DOES SEMAGLUTIDE/TIRZEPATIDE REALLY WORK?

Semaglutide/Tirzepatide is not a universal solution for everyone, but during clinical studies, those on the medication on average experienced between 5%-15% loss of body weight. For the best results, this treatment is most effective with healthy lifestyle changes.

WILL MY INSURANCE COVER SEMAGLUTIDE/TIRZEPATIDE?

Insurance companies may provide coverage for Semaglutide/Tirzepatide when it is prescribed for the treatment of type 2 diabetes. However, coverage for Semaglutide/Tirzepatide as a weight loss medication is not typical. However, it’s always best to check with your insurance provider.

CARE ADVICE

Semaglutide / Terzepitide

Your body will have optimal results when you maintain a regimen to support your health and well-being.

- **Storage**: Store the injections in the refrigerator and do not freeze. Throw away used needles in a rigid, closed container, and keep this container away from children and pets.
- **Eating Habits for Nausea**: Eat slowly and in smaller portions, drink clear liquids, and avoid lying down right after eating. Focus on foods that contain more water and maintain a regular meal schedule while limiting snacking between meals.
- **Fibrous Diet**: Emphasize a fibrous diet, including fruits and vegetables high in fiber.
- **Small, High-Protein Meals**: Opt for small, high-protein meals, as digestion is slowed while on this medication.
- **Low-Fat Foods**: Avoid foods high in fat as they may contribute to nausea and vomiting. Taking injections before meals, rather than after, is recommended to minimize potential side effects from eating high-fat or high-sugar foods.
- **Limit Alcohol Intake**: Avoid alcohol consumption while taking Semaglutide/Tirzepatide injections, as it can increase the risk of hypoglycemia, dehydration, nausea, and vomiting.
- **Caffeine**: Be cautious with caffeine consumption, as it may affect the action of Semaglutide/Tirzepatide, leading to low blood sugar levels or dehydration.

POLICY FORM

Cancellation

At Twin Ports Wellness and Aesthetics, we strive to provide an exceptional standard of care. We request your cooperation in adhering to our cancellation policy to achieve this.

We understand that life can be unpredictable, and unexpected circumstances may arise. However, please provide us with at least 24 hours' notice if you need to cancel or reschedule your appointment. Your deposit will be refunded or applied to a new appointment.

Cancellations made within 24 hours of the scheduled appointment time are subject to a $50 cancellation fee.

While we understand that unforeseen circumstances can occur, a missed appointment where no notice is given affects our ability to serve other clients and results in lost time and resources. The total cost of the service is charged for these appointments.

We value your time as well as the time of our other clients. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your session or shorten the treatment duration. The total price of the initially scheduled appointment will still apply.

We truly appreciate your understanding and cooperation in honoring our cancellation policy to ensure each client receives the attention and quality service they deserve.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

HIPAA Information and Consent Form

Name:_________________________________Date of Birth_______________

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

The following policies are what we have adopted here at our office:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name______________________________________
Signature____Date_______________________

Weight Loss fee acknowledgment and Insurance Disclaimer

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, injections, Laser or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. **WE WILL NOT**, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

Semaglutide monthly fee..$400.00
Tirzepatide monthly fee..$______

Client Name (printed)	Client Name (signed)	Date

RELEASE FORM

Photo & Video

I, ______________________________ grant and authorize ______________________________ the right to take, edit, alter, use and publish photographs and/or videos of me for the purpose of promotional materials, including but not limited to:

- Print advertisements
- Online marketing (websites, social media, blogs)
- Educational materials (brochures, flyers, presentations)

I acknowledge that all photographs and/or videos taken are the property of Twin Ports Wellness and Aesthetics and will be used solely for the purposes stated above.

I understand that by signing this release form, I grant Twin Ports Wellness and Aesthetics permission to take, edit, alter, use and publish my photographs and/or videos without any further compensation or consideration. I waive any rights to compensation, financial or otherwise, for the use of these photographs and/or videos.

i release Twin Ports Wellness and Aesthetics, its representatives, and employees from any claims, damages or liabilities that may arise from the use of the photographs and/or videos, including any claims for compensation, defamation, or invasion of privacy.

By signing below, I acknowledge that I have read this release form, understand its content, and voluntarily agree to its terms.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date