InShapeWV

Patient Medical History

Patient Last Name: _____ First: _____ M.I. _____

Birthdate: _____ Age: ____ Gender: M F Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How did you hear about us? _____

Occupation: _____

Reason for visit: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Present Status:

1. To the best of your knowledge, are you in good health at the present time? Yes No
   Explain a "no" answer:

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?

3. Are you taking any medications at the present time? Yes No

Prescription Drugs: (list all)

Drug Name: Dosage:

1. _____
2. _____
3. _____
4. _____

Over-the-Counter medications, vitamins, supplements: (list all)

Name: Dosage:

1. _____
2. _____
3. _____

InShapeWV

Past Medical History: (check all that apply)

_____Epilepsy	_____ Measles	_____Pancreatitis
_____Jaundice	_____Mumps	_____Liver Disease
_____Kidney Stones	_____Scarlet Fever	_____Thyroid Disease
_____Kidney Disease	_____Whooping Cough	_____Diabetes
_____Rheumatic Fever	_____Bleeding Disorder (Blood Clot)	_____Nervous Breakdown
_____Ulcers	_____Gout	_____Psychiatric Illness
_____Anemia	_____Heart Valve Disorder	_____High Blood Pressure
_____Tuberculosis	_____Gallbladder Disorder	_____Heart Attack/Heart Disease
_____Drug/Alcohol Abuse	_____Eating Disorder	_____Glaucoma
_____Pneumonia	_____Depression	_____Lung Disease
_____Cancer (Type) _____	_____Arthritis/Osteoporosis	_____Other_____

Smoker: No _____ Yes _____ If yes, how much? _____ **Current Weight**: _____
Labs within the last year: No _____ Yes _____ Where?_____
EKG within the last year: No _____ Yes _____ Where?_____
Females: Date of most recent pap**:** _____ Date of Last Menstrual Cycle**:** _____
If over 40, date of most recent mammogram: _____ Method of Birth Control _____
Have you ever been diagnosed with: Fibrocystic breast disease _____ Endometriosis _____ PCOS (Polycystic Ovarian Syndrome) _____ Leiomyoma (uterine fibroids) _____ Endometrial Polyps _____
Do you currently suffer from: Severe Acne ____ Facial Hair _____ Breast Tenderness _____
When you had periods did/do you have pre-menstrual migraines _____

Surgeries: Specify: (list all) Date

_____
_____
_____

History of Sleep Apnea? Yes _____ No _____

Allergies to any medications? Yes _____ No _____
Please list medication and reaction:

_____

Family History: (as it relates to obesity)

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Siblings:					

Patient's Signature _____ **Date** _____

bioTE® MEDICAL

BHRT Checklist For Men

Name: _____ Date: _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Consolidated Patient Release and Consent Form

Patient Name: _____

Date: _____

INITIAL EACH:

_ I certify that I will not seek to be reimbursed by Medicare, Medicaid, Tricare or any other government entity. Additionally, I agree that I am financially responsible for payment of all lab tests, treatments, programs or medications prescribed by InShapeWV® at my request.

_ I understand that lab test results may become part of my medical record. I also understand that an insurance company may discover the results of the testing by obtaining a copy of my medical records in accordance with the terms of my insurance policy(ies). I understand that my test results will only be provided to other third parties upon my express written consent.

_ I have had the opportunity to have any questions answered that I may have regarding my right to privacy by an employee of InShapeWV®. I have received a copy of the Notice of Privacy Practices, as required by Health Insurance Portability and Accountability Act (HIPPA) from InShapeWV® or I have chosen not to receive a copy.

_ I have had the opportunity to have any questions answered that I may have regarding weight loss semaglutide, tirzepatide, contave, topamax, and appetite suppressants including phentermine and phendimetrazine giving InShapeWV® permission to treat.

_ I have read and understand the consent form for Bioidentical Hormone Replacement Therapy (BHRT), and have had the opportunity to have any questions answered that I may have including Testosterone and BioTE, giving InShapeWV® permission to treat.

_ I have had the opportunity to have any questions answered that I may have regarding Lipotropic Injections, including Lipo and MIC-B12 (Methionine, Inositol and Choline with Methyl B12) giving InShapeWV® permission to treat.

_ I acknowledge that no guarantees have been made to me concerning the results of the prescribed program(s). I further understand that I am freely and voluntarily agreeing to the treatment plan suggested by InShapeWV® and I am giving full consent to proceed with treatment(s) as recommended.

_ I have also been informed that there are other risks, which include but are not limited to severe loss of blood, infection and cardiac arrest, and all potential risks or adverse events that are attendant to the administration of any restricted calorie diet, medications, hormones or invasive procedures such as a subcutaneous or intramuscular injection.

956 North Eisenhower Dr, Beckley, WV 25801
Phone: (681) 238-5258 • Fax (681) 238-5700
Email: inshapewv@gmail.com • Website: www.inshapewv.com

InShapeWV

_ I agree that I will **NOT** obtain additional controlled substances including **Testosterone** and/or **Appetite Suppressants** from other health care providers. If discovered otherwise, I understand that I will be discharged from the InShapeWV® immediately. No exceptions!

_ I agree that I will **NOT** seek or receive Hormones, including Testosterone or medications for Sexual Dysfunction from InShapeWV® if convicted or registered as a sex offender. I agree to disclose this information to InShapeWV® practitioners prior to treatment. If discovered otherwise, I understand that I will be discharged from the InShapeWV® immediately. No exceptions!

_ I understand the practitioners at InShapeWV are NOT my primary care provider or physician. Furthermore, I will discuss all diet programs, hormones or medications received from InShapeWV with my primary care provider.

Signatures:

1. **Counseling Practitioner:** I have counseled this patient in layman's terms as to the nature of the proposed treatment plan, including restricted diets, medications and hormones, attendant risks involved and expected resulted.

_____

(Signature of Counseling Practitioner)

2. **Patient:** I understand the nature of the proposed treatment plan, including restricted diets, medications and hormones, attendant risks involved and expected results and freely agree to proceed.

_____

(Signature of Patient)

_____

(Date)

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed _____ Date:_____

Relationship (if not signed by the patient:_____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time) _____

By (name and title) _____

InShapeWV
956 N. Eisenhower Dr.
Beckley, WV 25801
(681) 238-5258 office
(681) 238-5700 fax
inshapewv@gmail.com

Cancellation/No Show Policy

We would like to thank you for being a patient in our office. We value our patients and strive to provide the best possible care in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. **Beginning 04/01/2022 we kindly ask that if you must change or cancel an appointment, please give us at least a 24 hours' notice. If such advance notice is not received, you will be financially responsible for the appointment you missed and your credit or debit card on file will be assessed an appointment fee of $50.** We understand that occasional missed appointments can occur for a variety of reasons, but when you miss an appointment without canceling, we are still responsible to pay our providers and staff for their time. However, when giving us a 24 hours' notice that gives us an opportunity to reach out to other patients who would like to come in sooner. We submit a text appointment reminder the day before your scheduled appt, if you must cancel or reschedule you may reply to the text stating so and we will promptly take care of your needs.

CREDIT/DEBIT

VISA # _____ _____ _____ _____ CV Code _____ Expiration Date_____

MasterCard # _____ _____ _____ _____ CV Code _____ Expiration Date_____

DISCOVER # _____ _____ _____ _____ CV Code _____ Expiration Date_____

Name on Card _____

Billing Address _____

_____

Acceptance of Policy
I have read and do understand the contents of this form and am authorizing InShapeWV to charge my credit/debit card on file should I miss an appointment or cancel with less than 24 hours notice. Please sign and date below indicating that you have read and understand the contents of this form.

_____
Patients Name (please print)

_____
Patients Signature

_____
Date

Informed Consent for Telemedicine Services

I understand that a telemedicine appointment is a regular phone call from the provider I am scheduled with. They will call me at my designated appointment time.

I understand that a telemedicine appointment is for my convenience, I can opt out of this service at any time, without effecting my right to future care or treatment.

I understand I have to come in for a face to face office visit then can have three consecutive telemedicine appointments before having to come in for another face to face office visit.

I understand that if I do not answer the phone at my designated telemedicine appointment time, I will be responsible for a $50 no show fee just as if I would if I did not show up to my in office appointment and the provider you are scheduled with will move on to the next patient on the schedule.

I understand I am responsible for letting the staff at InShapeWV know if my phone number has been changed. We have no way of knowing that your number has been changed unless we are told.

I understand that I am responsible for a $50 telemedicine call (even if I decide to not refill my medication at that time) just as I would for an in office visit. I am taking up an appointment slot that the provider sees patients.

I understand I have one week to pick up my medications from the date of my appointment or they will be cancelled and returned to stock and I will still be responsible for the $50 telemedicine call.

_____ _____

Print Name Patient Signature Date

Cell Phone Communication Consent Form

I, _____ (Patient Name),

☐ I consent to receiving text messages.

☐ I do not consent to receiving text messages.

InShapeWV to deliver or cause to be delivered the following types of messages by voice call or text messaging:

Appointment reminders
Visit recalls
Situational/seasonal service suggestions

I authorize such messages to be delivered to the following phone number(s):

Cellphone: _____

I understand that I am not required to sign this agreement in order to receive services from InShapeWV. I understand that my telephone company may impose charges on me for these services and I may revoke this consent at any time.

Signature: _____ Date: _____