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Patient Information

Last name: _____ First name: _____ M.I. _____

Date of birth: ____/____/_____ Age: _____ Sex at birth: Male ☐ Fema ☐

Address: _____
street apt/bldg #

_____
city state zip code

SS #: _____-_____-_____ Who referred you to us? _____

Occupation: _____ Employer: _____

Preferred phone #: (_____) _____-_____
May we leave a message containing your health information at this number? Yes ☐ No ☐

Email address: _____

In case of emergency, notify: _____ Phone #: (_____) _____-_____

Relationship to patient: _____ Patient's Primary Care: _____

Insurance Information

Policy holder: _____ Relationship: _____

Policy holder DOB: ____/____/_____ Policy holder SS#: _____-_____-_____

Address (if different from patient):_____
street apt/bldg #

_____
city state zip code

Insurance company: _____ Member ID #: _____

Group #: _____ Name on card: _____

Insurance company: _____ Member ID #: _____

Group #: _____ Name on card: _____

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Patient Demographics

as required by the federal government

Patient name: _____ **DOB:** _____

Please circle your race:

☐Native American ☐White ☐African American or Black ☐Asian

☐Native Hawaiian/Pacific Islander ☐Prefer not to specify

Please circle your ethnicity:

☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to specify

Please circle your sex at birth:

☐Male ☐Female

Please circle or provide your gender:

☐Male ☐Female other: _____

Please circle your smoking status:

☐never smoked ☐current daily smoker ☐current occasional smoker ☐previous smoker

Please circle your marital status:

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partner

_____ _____

signature

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I have received a copy of the interveneMD Notice of Privacy Practices.

Designation of Personal Representative

I, _____, hereby designate _____ as my personal representative for purposes of all rights, obligations and responsibilities created under the HIPAA Privacy Rules. I acknowledge and agree that interveneMD may disclose my protected health information to my personal representative and that my personal representative has the authority to authorize the practice to use and disclose my protected health information.

Insurance Disclosure and Payment Guarantee

I hereby authorize and direct payment of my medical benefits on my behalf for any services furnished to me by interveneMD. I understand that it is my responsibility to provide the most current insurance information and by not doing so could result in denial of my claims.

Insurance carriers will only pay for services determined to be covered and/or medically necessary under the terms of the policy. I understand that even if my insurance carrier has preauthorized the requested services, my insurance carrier may later determine it is not covered or medically necessary and deny payment for that service. I consent to be billed directly by interveneMD and Anesthesia Associates of Charleston for any services denied by insurance. I agree to be personally and fully responsible for payment should I receive or agree to services denied by my insurance.

No Surprise Billing Act

The No Surprises Act (NSA) protects the uninsured (or self-pay) and out of network individuals from many unexpectedly high medical bills. If you do not have certain types of health insurance or do not plan to use insurance to pay for health care items/services, you are eligible to receive a "good faith estimate" of what you may be charged before receiving an item/service. Once an uninsured or self-pay individual schedules an item or service with a healthcare provider or healthcare facility, that facility must give them a good faith estimate of the amount it expects to charge for that item/service. An individual may also request this estimate at any time regardless of whether they have scheduled the item/service.

Consent to Treatment

I give consent to Dr. Todd Joye, Jennifer Pedersen, PA-C and interveneMD staff to provide medical care including consultation, examination, diagnostic testing and treatment to me deemed appropriate. I acknowledge that no guarantees of effectiveness are expressed or implied, that I have the right to decide the extent of my health care, including referrals to other healthcare facilities or professionals, and that I may refuse or terminate treatment at any time.

_____ _____

print patient or responsible party name | date of birth

_____ _____

signature of patient or responsible party | date

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Policies and Procedures

Our first priority will always be providing reliable, quality healthcare to all patients in a timely manner. No-shows, late changes/cancellations, and late arrivals hinder our ability to fulfill this priority. Appointments rescheduled or cancelled within 24 hours of the scheduled appointment time are considered late.

Please note the following office policies:

1. Patients arriving >10 minutes late to their appointment will be rescheduled.
2. All late reschedules, late cancellations or no-shows will result in an automated $50 charge
3. Payments and co-payments will be collected prior to service.
4. A $30 form fee will be charged for any forms requiring your provider's signature occurring outside of a scheduled appointment.
5. There is a $25 fee for prescription refill requests made between appointments. Please note: we will not provide prescriptions for pain medications without an appointment.
6. Staff must be notified of any address, phone or insurance changes prior to your appointment.
7. Due to HIPAA privacy policies, all communication must be with the patient only, unless the patient signs a formal release of information to a designee.
8. Our office will do our best to obtain proper authorization from your insurance for your intended visit or procedure, however it remains your responsibility to ensure this authorization has been obtained prior to services rendered. Treatment without the necessary referral or authorization will result in denial of payment by your insurance company, placing full financially responsibility onto you.

If you need to cancel or change your appointment for any reason, please call us between the hours of 9am and 5pm Monday – Friday at (843) 216-4844 and we will be happy to assist you.

I have read and understand the above policy. I agree to pay any applicable fees as stated above.

_____ _____

print name of patient or responsible party date

_____ _____

signature of patient or responsible party date

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Pre-visit Questionnaire

Patient name: _____ DOB: _____/_____/_____

What is your reason for your visit today?

_____

_____

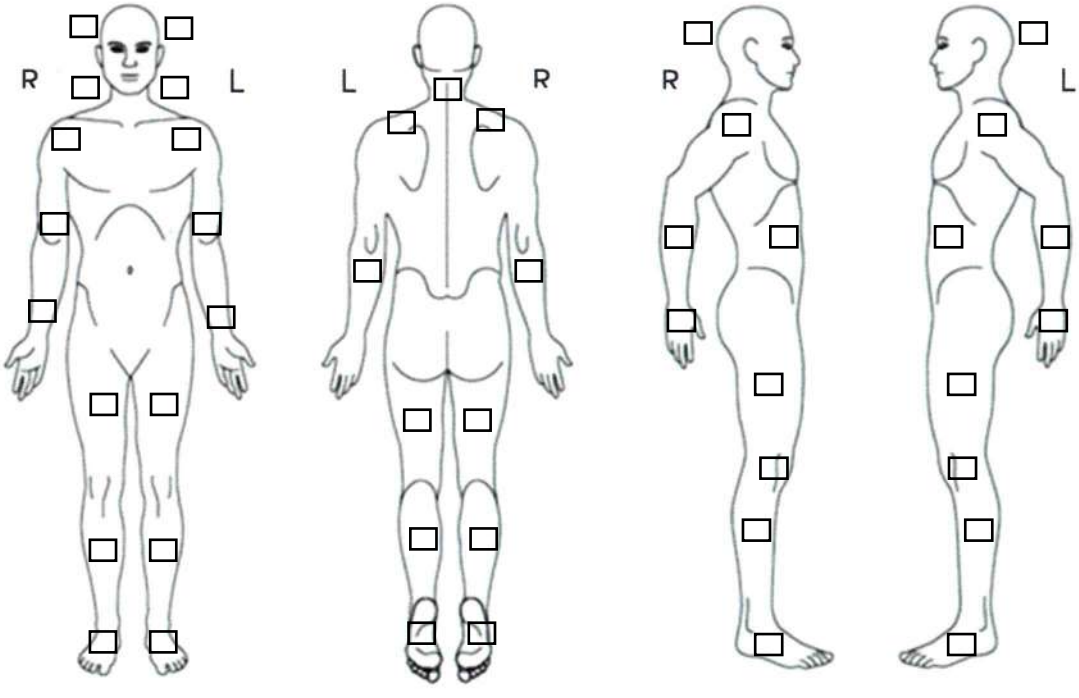
_____

If you are experiencing pain, what is your pain on a scale of 0-10?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

(no pain at all) (pain cannot be ignored/ unable to distract yourself from the pain) (pain so severe you cannot carry on a conversation)

Please mark the area of your discomfort below:



How would you describe this discomfort? (please circle)

Burning ☐ Stabbing ☐ Aching ☐ Pins & Needles ☐ Numbness ☐ Weakness ☐

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What therapies, treatments or medications have you tried for this problem so far? (please circle)

- ☐ Physical therapy
- ☐ Acupuncture
- ☐ Injections/Epidurals, etc.
- ☐ Chiropractic
- ☐ Peptides
- ☐ IV Infusions
- ☐ Massage
- ☐ Medications
- ☐ Shockwave Therapy

Which of these have resulted in improvements?

_____

Is your visit today in relation to a car accident/personal injury or legal case? Please list your attorney:

_____

Please circle all of the following within ***your family's*** history:

- ☐ Alcoholism/substance abuse
- ☐ Alzheimer's/dementia
- ☐ Bleeding or clotting disorder
- ☐ Cancer
- ☐ Chronic pain
- ☐ Depression/anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Thyroid disorders

Please circle all of the following within ***your personal*** history:

- ☐ Alcoholism/substance abuse
- ☐ Alzheimer's/dementia
- ☐ Bleeding or clotting disorder
- ☐ Cancer
- ☐ Chronic pain
- ☐ Depression/anxiety
- ☐ Diabetes/Pre-diabetes
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Thyroid disorders

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Please list any allergies to medications or supplements:

_____

Please list **all** medications and supplements you are currently taking or attach a list to this packet:

medication name	medication name	medication name

Please list any operations and the approximate year or decade they were performed:

_____ _____

_____ _____

_____ _____

_____ _____

How many alcoholic drinks do you consume per week? (please circle)

0☐ 1-3☐ 4-8☐ 8-12☐ 12+☐

Do you smoke cigarettes? Yes☐ No☐ If so, how much? _____

Do you vape/use electronic cigarettes? Yes☐ No☐ If so, how often? _____

About how many hours of sleep do you get per night? _____

Any difficulty falling asleep or staying asleep? (please circle) Falling asleep☐ Staying asleep☐ No☐

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Please complete the following checklist to the best of your ability:

General Health and Wellness

Appetite change	☐Y	N☐
Fever/Chills	☐Y	N☐
Headache	☐Y	N☐
Unexplained weight loss	☐Y	N☐
Difficulty losing weight	☐Y	N☐
Fatigue	☐Y	N☐
Difficulty sleeping	☐Y	N☐

Heart and Lung Health

Calf pain with walking	☐Y	N☐
Lower leg swelling	☐Y	N☐
Cough	☐Y	N☐
Sleep Apnea	☐Y	N☐
CPAP use	☐Y	N☐
Low stamina with activity	☐Y	N☐
High blood pressure	☐Y	N☐
Blood clot/stroke	☐Y	N☐
Heart attack	☐Y	N☐

Musculoskeletal Systems

Stiff or aching joints	☐Y	N☐
Arthritis	☐Y	N☐
Fibromyalgia Syndrome	☐Y	N☐
Neck pain	☐Y	N☐
Upper back pain	☐Y	N☐
Lower back pain	☐Y	N☐
Spine/joint hardware	☐Y	N☐
Spinal cord stimulator	☐Y	N☐

Gut and Digestive Health

Heartburn or indigestion	☐Y	N☐
Diarrhea or constipation	☐Y	N☐
Irritable bowel syndrome	☐Y	N☐
Crohn's/ulcerative colitis	☐Y	N☐
Irregular bowel habits	☐Y	N☐

Brain and Nerve Systems

Mental fogginess	☐Y	N☐
Memory difficulties	☐Y	N☐
Concentration difficulties	☐Y	N☐
Imbalance or instability	☐Y	N☐
Headaches or migraines	☐Y	N☐
Weakness/falls/tripping	☐Y	N☐
Numbness between legs	☐Y	N☐
New loss of bladder control	☐Y	N☐
New loss of bowel control	☐Y	N☐
Fainting/syncope	☐Y	N☐

Mental Health

Anxiety	☐Y	N☐
Depression	☐Y	N☐
PTSD	☐Y	N☐
In-patient psych care	☐Y	N☐
History of substance abuse	☐Y	N☐
Current substance abuse	☐Y	N☐

Immunologic and Endocrine Systems

History of or active cancer	☐Y	N☐
Gout/gouty arthritis	☐Y	N☐
Lupus	☐Y	N☐
Rheumatoid arthritis	☐Y	N☐
Low thyroid activity	☐Y	N☐
Elevated thyroid activity	☐Y	N☐
Pre-diabetes	☐Y	N☐
Poor/weak immune system	☐Y	N☐

Reproductive Wellness

Decreased libido	☐Y	N☐
Traumatic birth/delivery	☐Y	N☐
Currently pregnant	☐Y	N☐
Trying to conceive	☐Y	N☐

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Patient name: _____ DOB:_____

Current weight: _____lb Goal weight: _____lb

Have you taken semaglutide/Ozempic/ Wegovy in the past?

Yes No

If yes, how much weight did you lose?

_____lb

Please list all medications and supplements you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list any medication allergies:

_____ _____
_____ _____

Please check if you have a personal **or** family history of any of the following:

- ☐ Multiple Endocrine Neoplasia Syndrome type 2
- ☐ Thyroid Medullary Carcinoma
- ☐ Pancreatitis

Patient Information

Last name: _____ First name: _____ M.I. _____

Date of birth: _____/_____/_____ Age: _____ Sex at birth: Male ☐ Female ☐

Address: _____
street name apt/bldg #

_____
city state zip code

Preferred phone #: (_____) _____-_____
May we leave a message containing your health information at this number? Yes ☐ No ☐

Email address: _____

Please initial to confirm the following:

_____ I have reviewed a copy of the interveneMD Notice of Privacy Practices.

_____ I understand that this service is self-pay and my insurance information will not be collected or billed for office visits regarding semaglutide consultation/follow-up or semaglutide therapy.

_____ I give consent to Dr. Todd Joye, Jen Pedersen, PA-C and interveneMD staff to provide medical care including consultation, examination, InBody scanning and treatment to me as is deemed appropriate. I acknowledge that no guarantees of effectiveness are expressed or implied, that I have the right to decide the extent of my care, and that I may refuse or terminate treatment at any time.

_____ _____
patient signature date

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Semaglutide Medication Information

Your medication must be kept refrigerated. It is okay for this medication to temporarily remain out of the fridge during transport so long as it is kept in a cool, shaded place.

We recommend keeping syringes in their prescription bag when storing in your home refrigerator as the individual syringes do not contain any medication information. Drop used syringes into an empty detergent container and adhere provided sticker before disposing into the general garbage.

Be sure to inform any other healthcare providers that you have started this medication and your reason for starting this medication. If you must fast for surgery or lab work, inform your provider that you are taking this medication as food may linger in the stomach for longer than is typical.

Most side effects are temporary and should subside within the first few weeks. The most common side effects include nausea, vomiting, diarrhea, abdominal pain or cramping, constipation, indigestion, hypoglycemia, burping, and gas/flatulence. You may notice a temporary recurrence of these side effects each time your dose is increased.

As your appetite declines, you may notice your desire to drink fluids decline as well. We encourage you to increase your fluid intake beyond what you would normally consume in order to stay well-hydrated and avoid any constipation.

If you experience persistent nausea or vomiting, severe upper abdominal pain, fever/chills, considerable redness, warmth or drainage at the injection site, or severe constipation, contact our or office or seek immediate medical attention when necessary.

Office phone: (843) 216-4844
Office hours: Monday – Friday
9am-12pm and 1pm-5pm

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Preparing for Your InBody Scan

The following guidelines will ensure the most reliable results from the InBody scan. Please note that an ideal scan will take place in the morning *before* you've eaten anything that day.

1. **Don't** eat for 4 hours prior to your scan to ensure an empty stomach.
2. **Don't** drink any fluids for 2 hours before your scan to ensure an empty gut and bladder.
3. **Don't** exercise for 12 hours before your scan.
4. **Don't** shower or use a sauna/steam room immediately before your scan.
5. **Don't** drink caffeine on the day of your scan.
6. **Don't** apply lotion to the hands or feet before your scan.
7. **Don't** scan during menstruation or pregnancy.
8. **Do** drink 1-2 full glasses of water >2 hours prior to your scan to ensure adequate hydration of tissues.
9. **Do** use the bathroom prior to your scan.

Wear clothing and footwear that is easily removable. We will provide a gown for your comfort.

Office phone: (843) 216-4844
Office hours: Monday – Friday
9am-12pm and 1pm-5pm