PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Date of Birth: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Main Contact: _____ Alternate: _____Work#: _____

Email: _____ Sex: Male or Female (circle one)

Social Security# (optional): _____

Marital Status: Single Married Divorced Widowed (circle one)

Emergency Contact Information:

Contact Name: _____ Phone: _____ Alternate: _____

Relationship: _____

Physician:

Referring Physician: _____ Phone: _____

Primary Insurance:

Policy Holder: _____ Policy: _____Group/Acct: _____

Employer Name: _____ Employer Contact: _____

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

Secondary Insurance:

Policy Holder: _____ Policy: _____Group/Acct: _____

Employer Name: _____ Employer Contact: _____

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

***If Patient is a minor or Power of Attorney is involved in care:**

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____

MEDICAL HISTORY
1 of 3

NAME: _____ **D.O.B.** *I I*

REASON FOR VISIT TODAY:

ALLERGIES (Include medications, foods, Xray, dyes) or **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

MEDICAL HISTORY

2 of 3

SURGERIES and/or HOSPIALIZATIONS (Include all surgery in your lifetime. Attach extra sheet if necessary) or **NONE**

Type of surgery and/or Hospitalization	Date (approximate)	Hospital or city if known
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

TOBACCO HISTORY

Are you an active cigarette smoker? Yes No

Have you ever been a cigarette smoker? Yes No

If yes, I smoked an average of _____packs/day for _____years. I quit in _____ (year)

Do you use other tobacco products? Yes No

If yes, please specify

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? Yes No

Do you currently drink alcohol regularly? Yes No Rarely

If yes, approximately how many drinks per week (beer, wine, or liquor) _____ Have you ever used intravenous drugs? Yes No

MEDICAL HISTORY
3 OF 3

NAME: _____ **D.O.B.** *I I*

Condition	Yes	No	Family
Diabetes			
Chest Pain			
High Blood Pressure			
Heart Disease			
Heart Attack			
Stroke/CV A			
Heart Palpitations			
Pacemaker			
Headaches			
Kidney Problems			
Seizures			
Cancer			
Osteoporosis			
Bowel/Bladder Abnormalities			
Urine Leakage			
Blood Virus (HIV, Aids)			
Asthma or Breathing Difficulties			
Liver/Gallbladder Problems			
Eye Disorders			
COPD/Lung Issues			
Blood Clotting			
Lymphedema			
Smoking/ Tobacco Use			

Condition	Yes	No	Family
Allergies to Medication			
Environment Allergies			
Other Allergies			
Are you on Blood Thinners?			
Hernia			
Are you pregnant?			
Metal Implants			
Dizziness/Fainting			
Bone Fracture			
Skin Abnormalities			
Sinus Problems			
Sexual Dysfunction			
Nausea/Vomiting			
Ringing in your ears			
Rheumatoid Arthritis			
Kidney Stones			
Recent Cardiology Workup			
Other Implanted Devices			
Anxiety or Depression			
Radiation or Chemotherapy			
Thyroid cancer			
Thyroid problems			
Pancreatic Cancer			
Pancreatic Problems			

Please briefly explain any "yes" answers above:

_____
_____
_____
_____
_____
_____
_____
_____
_____

CONSENT FOR TREATMENT

I hereby give my permission for Lammons Healthcare & Associates, PLLC and its associates or assistants to examine and render treatment as may be necessary in the diagnosis and/or treatment of my weight management and release related information to my physician and/or emergency medical personnel as required by law. Treatment may include examination, medication administration, and other various weight management related/reasonable therapies.

Signature: _____ Date: _____

Printed Name: _____

Lammons Healthcare & Associates, PLLC. DBA WoundX
Argyle, TX 76226
(214) 831-6070

ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear and concise communication of our financial policies. Unfortunately, most insurance no longer covers services fully and many insurance plans chosen by our patients may require significant out-of-pocket expenses to be paid by the patient. With continuous changes in coverage, it is important to verify your benefits and be aware of all restrictions, limitations, and expenses of your plan.

It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with precertification for procedures ordered by our office, but your responsibility is to verify whether your insurance plan covers any care rendered. We are not responsible for the expense of treatment, which is not paid by your insurance.

I hereby authorize my insurance company to pay directly to Lammons Healthcare & Associates, PLLC the benefits and amounts due and otherwise payable to me for medical supplies and services, as described on the customary charges for all supplies and services. I acknowledge and understand that I am responsible for all the charges for all services rendered to me or any member of my immediate family. If for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt and timely payment of the balance. I further acknowledge that I read and understand the financial policy. I accept responsibility for the payment of any balance owed on my account. I understand I am financially responsible for all charges whether paid by insurance.

Signature: _____ Date: _____

Printed Name: _____

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Argyle, TX 76226
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MEDICARE (IF APPLICABLE)

I hereby authorize my insurance company to pay directly to Lammons Healthcare & Associates, PLLC the benefits and amounts due and otherwise payable to me for their services, but not to exceed the customary charges for those services. I understand that I am financially responsible for all remaining charges incurred whether or not covered by said insurance.

Signature: _____ Date: _____

Printed Name: _____

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PHOTO, VIDEO, AND AUDIT CONSENT

I hereby consent to allow Lammons Healthcare & Associates, PLLC., its agents, representatives, employees, successors, or assign to photograph, and/or videotape. I further grant to Lammons Healthcare & Associates, PLLC the right and permission to copyright, reproduce, broadcast, telecast, and/or publish the photograph(s), film, videotape, recordings, endorsement, or copy in which I may include in whole or part or composite form for utilization in diagnostics, documentation, treatment, and/or teaching or demonstration purposes, or art purposes, trade, website use, advertising, and all advertising media, or for any lawful reproduction purpose.

I understand that these images will be stored in a secure manner to protect them from unintended use by unauthorized parties. I understand and agree that these images/recordings may include inferring information regarding medical conditions and/or treatment at the Lammons Healthcare & Associates, PLLC locations and affiliated entities.

I understand and agree that I have the right to rescind this agreement and Lammons Healthcare & Associates, PLLC., will not make any additional media placement of my images or recordings. I also understand that Lammons Healthcare & Associates, PLLC., will not withdraw any media where my images or recordings have already been placed. To rescind approval, I must submit a request in writing to Lammons Healthcare & Associates, PLLC.

Signature: _____ Date: _____

Printed Name: _____

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AUTHORIZATION AND CONSENT FOR USE OF RECORDING DEVICES FOR MEDICAL DOCUMENTATION

Lammons Healthcare & Associates, PLLC (including WoundX) is committed to enhancing the accuracy, efficiency, and quality of medical documentation. As part of this process, recording devices may be used to capture verbal dictation of SOAP (Subjective, Objective, Assessment, and Plan) notes, which are then transcribed and entered into the Electronic Medical Record (EMR). This method improves workflow efficiency, ensures accurate and timely documentation, and enhances overall patient care.

By signing below, you acknowledge and agree to the following:

Authorization for Recording: You authorize Lammons Healthcare & Associates, PLLC and its designated providers to use audio recording devices to document SOAP notes for medical purposes. These recordings are intended solely for clinical documentation and will not be shared, distributed, or used for any purpose beyond patient care and recordkeeping.

Confidentiality & HIPAA Compliance: Lammons Healthcare & Associates, PLLC adheres to all HIPAA regulations and confidentiality standards to protect patient information. Recordings will be securely stored and deleted upon successful transcription into the EMR.

Efficiency & Accuracy: The use of recording technology streamlines documentation, reducing administrative burdens and ensuring the correct and complete logging of medical notes, leading to improved patient outcomes.

Limited Use & Access: Access to recorded dictations will be restricted to authorized medical personnel responsible for transcription and documentation. No recordings will be used for training, research, or any other non-clinical purpose without prior written consent.

Right to Revoke: You have the right to withdraw this authorization at any time by providing written notice to Lammons Healthcare & Associates, PLLC. However, withdrawal will not apply to recordings already transcribed and incorporated into the medical record.
Acknowledgment of Consent: You understand that this authorization is voluntary and that declining or revoking consent may require alternative documentation methods.

By signing below, you acknowledge that you have read and understand this authorization and consent to the use of recording devices for SOAP note documentation.

Signature: _____ Date: _____

Printed Name: _____

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AUTHORIZATION TO RELEASE INFORMATION

I, _____ hereby authorize Lammons Healthcare & Associates, PLLC., to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with claims. I may revoke consent for the above item at any time in writing. I also understand that there is a $25 non-refundable fee for any requested medical records or the completion of any forms, including FMLA, and others.

Signature: _____ Date: _____

Printed Name: _____

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Argyle, TX 76226
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PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND PRIVACY PRACTICES

I, _____ the undersigned, authorize payment of medical benefits to Lammons Healthcare & Associates, PLLC. for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Lammons Healthcare & Associates, PLLC. to release to my insurance company, referring physician, insurance companies and other consultants on my case information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Lammons Healthcare & Associates, PLLC.

NOTICE OF PRIVACY PRACTICES

Protected Health Information may be disclosed to insurance companies, managed care organizations, or referring physicians in the course of treatment, payment, or healthcare operations. When information is disclosed to another entity, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. You have the right to refuse or restrict disclosure of your information.

Signature: _____ Date: _____

Printed Name: _____

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CONSENT TO SEMAGLUTIDE OR TERZEPATIDE TREATMENT

Indications and Limitations of Use

Semaglutide/Terzepatide is an injectable prescription medication for adults with obesity (BMI ≥30) or overweight (excess weight) (BMI ≥27) who also have weight-related medical problems used with a reduced-calorie meal plan and increased physical activity.

Semaglutide/Terzepatide has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.

Semaglutide/Terzepatide is not a substitute for insulin. Semaglutide/Terzepatide is not indicated for use in patients with type 1 diabetes mellitus or for the treatment of patients with diabetic ketoacidosis.

Contraindications

Semaglutide/Terzepatide is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2, and in patients with known hypersensitivity to Semaglutide/Terzepatide or to any of the product components.
Warnings and Precautions

- Risk of Thyroid C-Cell Tumors: Patients should be referred to an endocrinologist for further evaluation if serum calcitonin is measured and found to be elevated or thyroid nodules are noted on physical examination or neck imaging.
- Pancreatitis: Acute and chronic pancreatitis have been reported in clinical studies. Observe patients carefully for signs and symptoms of pancreatitis (persistent severe abdominal pain, sometimes radiating to the back with or without vomiting). If pancreatitis is suspected, discontinue Semaglutide/Terzepatide promptly, and if pancreatitis is confirmed, do not restart.
- Diabetic Retinopathy Complications: In a 2-year trial involving patients with type 2 diabetes and high cardiovascular risk, more events of diabetic retinopathy complications occurred in patients treated with Semaglutide/Terzepatide (3.0%) compared with placebo (1.8%). The absolute risk increase for diabetic retinopathy complications was larger among patients with a history of diabetic retinopathy at baseline than among patients without a known history of diabetic retinopathy.
  Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. The effect of long-term glycemic control with Semaglutide/Terzepatide on diabetic retinopathy complications has not been studied. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy.
- Hypoglycemia: The risk of hypoglycemia is increased when Semaglutide/Terzepatide is used in combination with insulin secretagogues (e.g., sulfonylureas) or insulin.
- Acute Kidney Injury: There have been post marketing reports of acute kidney injury and worsening of chronic renal failure, which may sometimes require hemodialysis, in patients treated with GLP-1 receptor agonists. Some of these events have been reported in patients without a known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Monitor renal function when initiating or escalating doses of Semaglutide/Terzepatide in patients reporting severe adverse gastrointestinal reactions.

- Hypersensitivity: Serious hypersensitivity reactions (e.g., anaphylaxis, angioedema) have been reported with GLP-1 receptor agonists. If hypersensitivity reactions occur, discontinue use of Semaglutide/Terzepatide; treat promptly per standard of care, and monitor until signs and symptoms resolve. Use caution in a patient with a history of angioedema or anaphylaxis with another GLP-1 receptor agonist.

Tell your provider if you have a history of any of those listed.

Adverse Reactions

The most common adverse reactions, reported in ≥5% of patients treated with Semaglutide/Terzepatide are nausea, vomiting, diarrhea, abdominal pain, and constipation.

Drug Interactions

The risk of hypoglycemia may be lowered by a reduction in the dose of the secretagogue or insulin. Semaglutide/Terzepatide causes a delay of gastric emptying and has the potential to impact the absorption of concomitantly administered oral medications, so caution should be exercised.

Use in Specific Populations

There is limited data with Semaglutide/Terzepatide use in pregnant women to inform a drug-associated risk for adverse developmental outcomes. Discontinue Semaglutide/Terzepatide in women at least 2 months before a planned pregnancy due to the long washout period for Semaglutide/Terzepatide.

I understand that if I experience any negative side effects that I am to stop the drug immediately and contact my prescriber. I have had ample time to have my questions answered and consent to the use of Semaglutide/Terzepatide.

Patient Name: _____

Patient Signature: _____ Date: _____

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