



HUNTSVILLE EMOTIONAL WELLNESS CENTER

WELCOME TO OUR PRACTICE

Thank you for scheduling your appointment with our providers. We look forward to meeting you!

OFFICE POLICIES

Appointment Policy:

1. Patients are seen only by appointment. Please arrive 15 minutes prior to your first appointment with paperwork completely filled out prior to your arrival. You may fill out the paperwork through your online portal or by printing it off our website. **You will not be seen in our office unless all forms are filled out prior to your visit.**
2. Although we attempt to make reminder calls, **it is the patient's responsibility to remember and keep scheduled appointments**
3. A minimum of 24 hours notice is required for canceling or rescheduling an appointment.
4. You will be charged **\$50** for missed appointments and appointments which are canceled with less than 24 hours notice.

Prescription Refill Policy:

1. Prescriptions will be provided during your appointment. With your last refill, ensure you have an appointment with your provider for a medication refill *before* your medication runs out.
2. Medication refills will not be authorized outside of appointment times.
3. Please clarify the pharmacy we have on record is correct.
4. Patients are reminded not to walk into the clinic to request a prescription refill.

Specialty Paperwork Fees:

1. If you request special paperwork to be completed, you will be charged based on the amount of time required to complete the forms. This is up to the discretion of the provider.
2. Payment is the patient's responsibility and is due **prior** to finalized forms being sent.

Financial Responsibility:

1. Co-pays and Deductibles are collected prior to your appointment when you check-in. **If you have no insurance, payment in full is required and must be paid prior to your appointment at the time of check-in.**
2. If your insurance claim is denied or there is lack of authorization, you are responsible for the billed amount.

I have read and agree to the above policies

Signature of patient or parent (if minor)

Date



HUNTSVILLE EMOTIONAL WELLNESS CENTER

FINANCIAL ARRANGEMENTS

Who will pay for services NOT covered by insurance?	
Relationship to patient:	
Address:	
Home Phone #:	
Cell Phone #:	
Work Phone #:	

Please initial below:

_____ I understand that I am responsible for any services that may NOT be covered or paid by my insurance company.

_____ I understand that if I default on my account, it may be placed with a collection agency that will add additional collection fees of the unpaid balance. In addition, there could be the cost of attorney fees and court costs.

_____ I agree to pay all copays or appointment fees at the time of service.

_____ I agree to pay all missed appointment fees for any appointment I do not show up for or cancel without a 24 hour notice except in an emergency situation.

_____ I understand that there will be a \$25.00 service fee for any checks returned by my bank. I agree to accept full responsibility for such fees.

Patient Signature

Insured's Signature/Guarantor if Minor



HUNTSVILLE EMOTIONAL WELLNESS CENTER

PATIENT AUTHORIZATION AND CONSENTS

I hereby authorize Huntsville Emotional Wellness Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay all insurance benefits otherwise payable to me directly to the physician or physician group. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I am responsible for payments of services whether or not paid by the insurance. Should this account be turned over to collections, I am responsible for all cost of collections and reasonable attorney fees. I authorize Huntsville Emotional Wellness Center to initiate any necessary paperwork, claims, and formal complaints to insurance companies, commissions, or agencies on my behalf or my dependents behalf.

Signature of patient or parent (if minor)

Date

NOTICE OF PRIVACY ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to view and correct that record. We will not disclose our record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may get more information about your records by contacting a privacy officer or administrator. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how you may access your information. I acknowledge receipt of this Notice of Privacy Practices.

Signature of patient or legal representative

Date

Print name if signed on behalf of patient

Relationship

Employee Signature
(If attempt to give Privacy Notice Practices
was declined by patient)

Date



HUNTSVILLE EMOTIONAL WELLNESS CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received from Huntsville Emotional Wellness Center a copy of the “Notice of Privacy Practices”.

I understand that Huntsville Emotional Wellness Center may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment, healthcare operations and other legal obligations.

Huntsville Emotional Wellness Center reserves the right to modify the privacy practices outlined in the notice.

Signature of Patient

Signature of Patient Representative



HUNTSVILLE EMOTIONAL WELLNESS CENTER

HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, hereby authorize and give my consent to Huntsville Emotional Wellness Center to release any and all information to the following person(s):

Name	Relation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I do not wish to disclose any health information

Patient Signature

Date



HUNTSVILLE EMOTIONAL WELLNESS CENTER

WEIGHT LOSS & METABOLIC HEALTH PROGRAM INFORMED CONSENT

Purpose

This form provides informed consent for the use of compounded GLP-1 medications (Semaglutide + B12 or Tirzepatide + B12) as part of a supervised weight-loss program. It also confirms completion of injection training instruction.

Compounded Medication Notice:

- I understand compounded medications are not FDA approved.
- Potency, sterility, and stability may differ from commercially manufactured products.
- I agree to only use medications dispensed through Huntsville Emotional Wellness Center's approved pharmacy partners.

Benefits & Risks:

- Potential benefits: appetite reduction, improved glucose control, weight loss.
- Possible risks: nausea, vomiting, diarrhea, constipation, abdominal pain, dizziness, fatigue, reflux, gallbladder issues, pancreatitis, delayed gastric emptying, thyroid tumor risk (based on animal studies).
- I agree to report urgent symptoms such as severe abdominal pain, inability to hydrate, shortness of breath, or allergic reaction.
- Can reduce oral contraceptive absorption → consider backup contraception for 4 weeks after dose changes

Injection Training:

- I have been instructed on proper drawing up and injection technique.
- I understand how to store medication and dispose of needles safely.
- I understand the dosing schedule, titration plan, and when to contact the clinic.

Patient Responsibilities:

- Follow dose instructions exactly as provided.
- Attend follow-up visits every 4–12 weeks to monitor progress.
- Notify the provider of any new medical issues, surgeries, medications, or pregnancy

Consent:

- I acknowledge understanding of the risks and benefits of compounded GLP-1 therapy and injection training. I voluntarily consent to treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

Provider Signature: _____



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GLP-1 Patient Information Sheet

What These Medications Do

- **Blood sugar control** (for diabetes)
- **Weight loss** by reducing appetite and slowing digestion
- **Improving metabolic health** (A1C, insulin resistance)
- They are usually taken **once weekly** as an injection.

How to Take Your Weekly Dose

- Choose a consistent day each week.
- Inject into the **stomach, thigh, or upper arm**.
- Rotate injection sites every week
- If you miss a dose:
 - Take it within **4 days (96 hours)** of the missed dose,
 - Otherwise **skip** and take your next dose on your regular day.
- **Do not inject** if the medication looks discolored or has particles.

Common Side Effects

- These are usually mild and often improve over time:
 - Nausea, Decreased appetite, Constipation or diarrhea, Burping, heartburn, indigestion, Fatigue, Bloating/gas
- **Tips to reduce nausea:**
 - Eat smaller meals
 - Avoid greasy or fried foods
 - Stop eating when you feel full
 - Sip water throughout the day
 - Eat slowly

More Serious Side Effects - Call your doctor right away if you notice:

- Severe stomach pain that doesn't go away (possible gallbladder or pancreas irritation)
- Persistent vomiting
- Signs of dehydration (dizziness, very dry mouth, dark yellow urine)
- A lump or swelling in your neck (rare thyroid-related issues)
- Vision changes (especially with diabetes)

Contraindications (Reasons NOT to Use These Meds) - You should not use tirzepatide or Semaglutide if you have:

- **Personal or family history of medullary thyroid cancer**
- **History of MEN2 (multiple endocrine neoplasia type 2)**
- **Previous severe reaction** to a GLP-1 medication
- **Currently pregnant or planning pregnancy** (must stop at least 2 months before trying to conceive)
- **Severe stomach problems** like gastroparesis
- **History of pancreatitis** (use with caution)
- **Significant gallbladder disease** (use with caution)

What to Expect With Weight Loss

- Weight loss is typically **gradual**.
- Many people see results by **8–12 weeks**.
- Plateaus are normal; the medication continues to help even if progress slows.
- Combining with healthy eating + activity increases success.

Eating Tips While on tirzepatide or semaglutide eat 25–30g protein per meal

- Avoid: High-fat meals, large portion sizes, carbonated drinks early in treatment
- Focus on: Lean meats, eggs, tofu, vegetables + fiber, plenty of water (goal: 60–80 oz daily)
- Do not drink **alcohol on an empty stomach**



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Storage Instructions

- Keep vials **refrigerated** until use.
- After first use:
 - semaglutide can be stored at room temp for up to 56 days.
 - Tirzepatide should remain refrigerated.
- Never freeze.
- Protect from heat and sunlight.

Medication Disposal

- Used needles go in a **sharps container**.
- Never throw loose needles in the trash.

Important Reminders

- This medication works best when taken **consistently every week**.
- Keep all scheduled follow-ups for dose adjustments.
- Report any side effects that do not improve after 1–2 weeks.
- Do **not** combine with other weight-loss meds unless your provider approves.