WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

Please complete all blanks

Name: First: M.I. Last: DOB:

Mailing Address: City: State: Zip Code:

Phone #: Home: Cell: Occupation:

*Can we leave a detailed message on these numbers? Y or N (Please circle one)

*Preferred Method of contact? Phone Text Email (Please Circle)

Social Security # Email Address:

Please Circle: ***Sex***: M or F **Marital Status**: Single Married Divorced Widowed

Gender Identity: M / F / FTM / MTF / G

Race: American Indian or Alaska Native / Asian / Black or African American
Native Hawaiian / Other Pacific Islander / White / Other: _____

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

Emergency Contact Information: Name: _____ Phone No: _____
Relationship to Patient: _____

Insurance Information: (Please provide insurance cards to receptionist)

Insurance Policy Holder Information (if other than patient):
Name: _____ Date of Birth: _____ Phone #: _____
Social Security No: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____

Parent or Guardian Information (if patient is younger than 18):

Name: _____ Date of Birth: _____ Phone #: _____
Address: _____ City: _____ State: _____
Zip: _____ Relationship to Patient: _____

I am interested in learning about the following services/products:
Refractive Surgery Vitamins for Eye Health Cosmetic Procedures Skin Care

The above information is true and correct to the best of my knowledge:

Signature: _____ Date: _____

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby agree and give my consent for West Tennessee Eye Care, P.C. to furnish medical care and treatment to myself or _____ which is considered necessary and appropriate in diagnosing or treating my/their physical condition.

STATEMENT OF FINANCIAL RESPONSIBILTY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at the time of treatment unless prior arrangements have been made with our office. I understand that in the event that my account is placed with a collection agency, a collection fee of up to 33.3% may be added to my account and shall become a part of the total amount due. In the event my account is placed with an attorney, I will be responsible for reasonable attorney fees and court costs. I agree, that in order for you to service my account or to collect any amounts I may owe, WTEC and your collection agencies may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. WTEC and your collection agencies may also contact me by sending text messages and/or emails, using any email address I provide to use. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize West Tennessee Eye Care, P.C. to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment or benefits to be made directly to West Tennessee Eye Care, P.C. for services provided to me or my dependents.

MEDICARE and/or MEDIGAP ONE-TIME AUTHORIZATION

I request that payment for authorized Medicare and/or Medigap benefits be made on my behalf to West Tennessee Eye Care, P.C. for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

CLAIM FILING CONSENT

I agree to give Medical Insurance Filing Services, Inc. authorization to file insurance for medical claims on behalf of West Tennessee Eye Care, PC.

ADVANCED DIRECTIVES

I have a living will or durable power of attorney. ___ Yes ___ No
If you do have a durable power of attorney, please identify: _____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received West Tennessee Eye Care's Notice of Privacy Practices.

_____ _____
Name of Patient Patient's Date of Birth

_____ _____
Signature of Patient/Guardian/Parent Date

This acknowledgement page should be retained in patient's record. If acknowledgement could not be obtained for patient, the reasons must be documented.

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we still strive to help you receive you maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rest with the patient.

Our office participates with most major insurance plans, both vision and medical. We provide medical and surgical ophthalmologic care to our patients, as well as routine eye exams. Therefore, if your current insurance plan requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit prior to being worked up by our technicians.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance, and deductibles.
- Bring all of your current insurance cards to all visits. Provide our office with current information including address, phone numbers, and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We accept cash, checks, and most major credit cards.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you, Any payment made by check that does not clear your bank account will result in a $25.00 fee, which will be added to your account and must be paid before the next visit

For all services rendered to minor/dependent parties, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used

Refunds:

If a requested refund is approved, then your refund will be processed to the original form of payment except cash payments. All check and cash payments will be refunded by check and mailed to the address on file. All payments by credit or debit card will be refunded the amount charged by the clinic, minus the credit card processing fee. This amount is determined by the percentage set by the POS system.

I have read and understand the above financial policy.

_____

Printed Name of Patient

_____ _____

Signature of Patient/Guardian/Parent Date

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

Vision Plans versus Medical Insurance - Explanation of Coverage

We often have patients that have both a vision plan and medical insurance. Vision plans and medical insurance are very different terms of the services they cover and it's important for our patients to understand those differences.

Vision Plans

Vision plans cover a routine comprehensive eye exam, including refraction, when the patient's only complaint is vision related (fixed by glasses or contact lenses) or when the patient has no eye complaint at all. If you have complaints or if you have known eye problems which require being followed by a doctor, your vision insurance will not cover the visit. You would then be financially responsible for the examination if you do not want it sent to your medical insurance. Common eye complaints NOT covered by vision plans include but are not limited to: redness, tearing, itching, dryness, headache and floaters.

Medical Insurance

Your medical insurance **WILL** consider any eye exam and testing related to a non-vision (glasses or contacts) related complaint, any ongoing medical eye issue and many systemic medical symptoms and diseases which can affect the eyes. Examples include but are not limited to: headaches, high blood pressure, diabetes and thyroid issues, as well as redness, tearing, itching, dryness, headache and floaters. Your medical insurance will **NOT** cover routine vision complaints or refraction. You may elect to pay for these procedures, which range from 40-95 dollars.

For the convenience of our patients, West Tennessee Eye Care, PC dba Toyos Clinic participates with most every major vision plan and medical insurance carrier. As required, we will file those claims for you. In the event that we do not participate with your medical insurance or vision plan, we will provide you with an itemized receipt so that you may file with your insurance carrier for any out-of-network benefits to which you may be entitled. If you have any questions, please let us know.

I acknowledge understanding of the information above and authorize West Tennessee Eye Care, PC dba Toyos Clinic to file claim(s) with my insurance(s) as appropriate.

_____

Printed Name of Patient

_____ _____

Signature of Patient/Guardian/Parent Date

Toyos Clinic - Medical History Questionnaire

Name: _____ Age/Race/Gender: _____ Date: _____

Other Doctors participating in your care (Name/Specialty/Location): _____

_____

Reason for today's exam: _____

Family History: Do your parents, siblings, or children have any of the following? Please circle and indicate the relationship.

Diabetes High Blood Pressure Cancer Retinal Detachment Glaucoma Blindness

Other Details: _____

Personal History: Are you currently taking medication for or have you ever been diagnosed or treated for the following conditions?

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Heart Attack
- ☐ Murmur
- ☐ Angina
- ☐ Pacemaker or Bypass
- ☐ Congestive Heart Failure
- ☐ Irregular Heart Beat
- ☐ Valve Replacement

CONSTITUTIONAL

- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Sleep Disorder

ENDOCRINE

- ☐ Thyroid Abnormality
- ☐ Diabetes: Insulin Dependent
- ☐ Diabetes: Non-Insulin Dependent

EARS, NOSE, MOUTH, THROAT

- ☐ Seasonal Allergies
- ☐ Sinus Congestion
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

GENITOURINARY

- ☐ Kidney
- ☐ Stones
- ☐ Prostate Disorder
- ☐ STD

GASTROINTESTINAL

- ☐ Diarrhea
- ☐ Constipation
- ☐ Reflux
- ☐ Gerd

HEMATOLOGICAL/LYMPHATIC

- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Hepatitis B/C
- ☐ HIV/AIDS
- ☐ Tuberculosis

IMMUNOLOGIC

- ☐ Cancer Type: _____

INTEGUMENTARY

- ☐ Eczema
- ☐ Skin Cancer

MUSCULOSKELETAL

- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Paralysis
- ☐ Lupus
- ☐ Gout
- ☐ Other: _____

NEUROLOGICAL

- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Multiple Sclerosis

PSYCHIATRIC

- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Schizophrenia
- ☐ Insomnia
- ☐ Mental Illness

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Pneumonia
- ☐ Asbestos

OCULAR

- ☐ Glasses
- ☐ Contact Lenses
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Laser Eye Surgery
- ☐ Trauma
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Lazy Eye
- ☐ Crossed Eyes
- ☐ Keratoconus
- ☐ Cataract Surgery
- ☐ Laser Treatment
- ☐ Injuries
- ☐ Other Eye Surgery

Other/Details: _____

General Surgeries: _____

Allergies to Medications: _____

Date of your last eye exam: _____

How are you currently managing your vision condition?

☐ Glasses How old are your current glasses? _____

Do your glasses have prism?

☐ Yes ☐ No ☐ Unsure

Are you currently wearing contacts? _____

How many years have you worn contacts? _____

Type: ☐ Soft ☐ Toric ☐ RGP ☐ Scleral

Brand: _____

Please circle answer.

Social History: **Smoking Status:** Never Smoker / Non-Smoker / Current Smoker -- Amount: _____

Alcohol Consumption: Heavy / Moderate / Occasional / Never

Recreational Drug Use: Yes / No

Medications: Please list all medications you are currently taking. Include eye drops, vitamins, and homeopathies. If you have a pre-printed list, please allow the receptionist to make a copy.

Name of Drug	Dosage	What is the medication for?

Preferred Pharmacy: _____ **Pharmacy Phone Number:** _____

Patient's Signature: _____ **Date:** _____

ToyosClinic

See Better, Look Better

Date: _____

Name: _____

Current Weight _____lbs Height: _____

Please answer the following questionnaire as completely as possible.

- Who is your primary care physician/family doctor? _____
- How did you find out about Toyos Clinic? (check one)

  ___ Advertisement: Billboard Flyer Health Fair Newspaper Other

  ___ Friend/Family/Coworker

  ___ Internet

  ___ Physician

  ___ Other
- What is the most you have weighed as an adult? _____lbs. Age at this weight? _____
- What is the least you have weighed as an adult? _____lbs. Age at this weight? _____
- What would you like to weigh? _____lbs. Age at your goal weight? _____
- How has your weight changed during your life? (check all that apply)

  ___ Gradual increase with a small amount each year

  ___ One or more rapid increase(s) in weight

  ___ Up and down
- What has caused you to gain weight in the past? (check all that apply)

  ___ Death/Illness of Family/Friend, describe: _____

  ___ Illness, describe: _____

  ___ Injury, describe: _____

  ___ Quitting Smoking, describe:_____

  ___ Menopause, describe: _____

___ Medications, describe:_____

___ Stress, describe: _____

___ Other, describe: _____

- What are you hoping the Weight Loss Medicine can do for you? (check all that apply)

  ___ Improve health/Feel better

  ___ Increase energy/Allow me to do more daily activities

  ___ Lose Weight

  ___ Prevent medical problems

  ___ Reverse medical problems/Allow me to stop medications

  ___ Other, describe: _____

- Have you ever had weight loss surgery? ___ Yes ___ No

  If yes, What type of surgery? _____ Date: _____ Weight lost: _____

- Are you interested in weight loss surgery? ___ Yes ___ No

- Please indicate on the lists below which of the following diet(s), diet aid(s), or program(s) you have tried in the past. For those you have tried, please enter the date started, date stopped, amount of weight lost, reason for stopping the diet, diet aid, or program, and reason for weight regain after stopping.

Name of diet or program	Check If tried	Start Date	Stop Date	Amount of weight lost	Reason for stopping	Reason weight regained after stopping
On your own	_____					
Atkins or low carb	_____					
UAB EatRight	_____					
Jenny Craig	_____					
Nutrisystem	_____					
Weight Watchers	_____					
Slimfast	_____					
Optifast	_____					
Ozempic	_____					
Other Semaglutide Products	_____					
Other liquid diet	_____					
Other (specify) _____	_____					

Name of diet or program	Check if tried	Start Date	Stop Date	Amount of weight lost	Reason for stopping	Reason weight regained after stopping
Adipex®, Fastin® (phentermine)	_____					
Alli®, Xenical® (Orlistat)	_____					
Belviq® (Locaserin)	_____					
Dexatrim®	_____					
Herbal weight loss products	_____					
Meredia® (Sibutramine)	_____					
PehnOfen	_____					
Qsymia®	_____					
Redux®	_____					
Other (specify) _____	_____					

- Are you taking any type of birth control? _____Yes _____No
  If yes, type of BC _____
- How many children under age 18 live with you? _____

  ___ Child(ren) ___ Grandchild(ren) ___ Other
- Please check if any family members are (or were) overweight or obese:

  ___ Spouse ___ Son ___ Daughter ___ Father ___ Mother

  ___ Sister ___ Brother ___ Grandparent ___ Other
- Will your family support you in your weight loss? ___ Yes ___ No ___ Maybe
- Please indicate if you have a history of any of the following:
  - Eating disorder ___ Yes ___ No ___ Not Sure
  - Anorexia Nervosa ___ Yes ___ No ___ Not Sure
  - Binge Eating ___ Yes ___ No ___ Not Sure
  - Bulimia/intentional vomiting ___ Yes ___ No ___ Not Sure
  - Eating so much at once that you have to vomit ___ Yes ___ No ___ Not Sure

PLEASE ANSWER THE FOLLOWING SLEEP/RESTFULNESS QUESTIONS

- On average over the past month, how many hours of sleep did you get per night? _____
- Do you feel rested when you wake up? ___ Yes ___ No
- Do you snore? ___ Yes ___ No
- Have you ever been told to wear a CPAP or BiPAP for sleep apnea? ___ Yes ___ No

If yes, how many nights per week? _____

- How well have you slept over the past month?

  ___ Very good ___ Fairly good ___ Fairly Bad ___ Very bad

- Check the choice for how likely you are to doze off or fall asleep in the situations described below, in contrast to feeling just tired. This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to think about how they would affect you.

Situation	Would Never Doze	Slight Chance	Moderate Chance	High Chance
Watching TV	___0	___1	___2	___3
Sitting and reading	___0	___1	___2	___3
Sitting in a public place (theater or meeting)	___0	___1	___2	___3
Passenger in a car for 1+ hour	___0	___1	___2	___3
Lying down to rest in the afternoon	___0	___1	___2	___3
Sitting down and talking to someone	___0	___1	___2	___3
Sitting quietly after a lunch (without alcohol)	___0	___1	___2	___3
In a car, while stopped for a few minutes in traffic	___0	___1	___2	___3

Total: _____

ADDITIONAL INFORMATION RELATED TO EXERCISE

- On a typical day, which describes you?

___ Mostly sitting ___ Mostly walking ___ Mostly heavy labor ___ Unsure

___ Other: _____

- Please check yes or no for the following:
    - Do you enjoy exercise? ___ Yes ___ No
    - Do you have a gym membership? ___ Yes ___ No
    - Do you have exercise equipment at home? ___ Yes ___ No
    - Do you exercise regularly? ___ Yes ___ No
    - Do you have any negative feelings about exercise or had any bad experiences with exercise? ___ Yes ___ No
    - Do you have any family members or friends who are willing to encourage you to exercise or possibly exercise with you ? ___ Yes ___ No
- How much exercise have you done in the past WEEK?

Type of Exercise: _____

Length of Exercise: _____ minutes _____ times per week

- How long have you been exercising regularly (at least 150 minutes per week; such as 5 days per week for at least 30 minute sessions)? _____ months
- What types of exercise are you currently involved in? (check all that apply)

  ___ Aerobics classes ___ Biking, outdoor ___ Biking, stationary ___ Crossfit/boot camp

  ___ Elliptical machine ___ Exercise videos ___ Hiking ___ Pilates ___ Running

  ___ Stretching ___ Swimming ___ Walking ___ Water/pool exercise

  ___ Weight training ___ Yoga ___ Zumba ___ None ___ Other: _____
- What type of exercise do you prefer or would you enjoy the most? (check all that apply)

  ___ Aerobics classes ___ Biking, outdoor ___ Biking, stationary ___ Crossfit/boot camp

  ___ Elliptical machine ___ Exercise videos ___ Hiking ___ Pilates ___ Running

  ___ Stretching ___ Swimming ___ Walking ___ Water/pool exercise

  ___ Weight training ___ Yoga ___ Zumba ___ None ___ Other: _____
- Were you an athlete in school? ___ Yes, High School ___ Yes, College ___ No
- How confident are you that you coul increase the amount of exercise you do? (check one)

  ___ Very confident ___ Moderately confident ___ Not very confident ___ Not confident

- What are the major benefits of exercise for you? (check all that apply)

  ___ Increased energy ___ Improved health ___ Improved arthritis ___ Improved mobility

  ___ Other: _____

- What are your major barriers to increasing the amount of exercise you do? (check all that apply)

  ___ Lack of motivation ___ Lack of time ___ Lack of equipment

  ___ Lack of access to exercise facilities ___ Injuries ___ Health problems

  ___ Other: _____

- How much time are you willing to commit to exercise? _____ minutes/day _____ days/week

ADDITIONAL INFORMATION RELATED TO DIET

- How confident are you that you can follow a weight loss diet? (check one)

  ___ Very confident ___ Moderately confident ___ Not very confident ___ Not confident

- What are your major barriers to following a weight loss diet? (check all that apply)

  ___ Access to healthy foods ___ Access to cooking appliances (stove, microwave, grill)

  ___ Access to refrigerator and/or freezer ___ Cost ___ Family/household diet

  ___ Food intolerances/dislikes ___ Healthy food doesn't taste good ___ Hunger

  ___ Lack of family/peer support ___ lack of knowledge of food to eat/buy ___ Religion

  ___ Time to plan/prepare healthy diet ___ Work atmosphere

  ___ Other: _____

- How many times a day do you eat? _____

- At what times of day do you eat? ___ Morning ___ Mid-morning ___Noon ___Afternoon ___ Evening ___ Late night/bedtime ___ Middle of the night

- How many people live in your home? _____ Are meals eaten together? ___ Yes ___ No

- Who does the grocery shopping? ___ Self ___ Spouse ___ Parent ___ Other: _____

- Who cooks/prepares meals? ___ Self ___ Spouse ___ Parent ___ Other: _____

- Have you done or experienced any of the following in the past 6 months?

	Y/N	Details/Comments
Eating when stressed, emotional, or bored	Y/N	
Binge eating	Y/N	

Grazing or frequent snacking	Y/N	
Eating in the middle of the night	Y/N	
Skipping meals	Y/N	
Eating out at restaurants or ordering takeout	Y/N	
Eating in front of the tv	Y/N	
Eating at a desk/computer/while working	Y/N	
Eating more than one helping/large portions	Y/N	
Do NOT feel satisfied or full after a meal	Y/N	

- Which of the following do you consume more than once a week? If so, how many times per day on average?

  ___ Regular soda _____ per day

  ___ Juice _____ per day

  ___ Sweet Tea _____ per day

  ___ Alcoholic drinks _____ per day

  ___ Fried foods _____ per day

- Please indicate the number of servings of each that you typically consume during an average day:

  _____ servings of fruit per day

  _____ servings of vegetables per day

  _____ servings of whole grains per day

  _____ servings of low fat dairy per day

  _____ servings of lean protein per day

- Do you have any food intolerances or food allergies, or are there particular foods that you dislike? ___ No ___ Yes, list: _____

- Do you have any food cravings? ___ No ___ Yes, list: _____

PAST MEDICAL HISTORY

___ Diabetes, age at diagnosis _____

___ Damage to kidneys from diabetes

___ Damage to eyes from diabetes

___ Damage to nerves from diabetes

___ Depression

___ Anxiety

___ Cataracts

___ Glaucoma

___ Obstructive sleep apnea

___ High blood pressure

___ High cholesterol

___ Thyroid disease

___ Arthritis

___ Cancer, type: _____

___ Heart attack(s)

___ Heart murmer/valve problems

___ Heart failure

___ Organ transplant, type: _____

___ Polycystic Ovarian Disease

___ Kidney stones

___ Pancreatitis

___ Pulmonary embolism

___ Reflux/heartburn

___ Gallstones

___ Colitis

___ Other medical conditions, list:

___ Other eye diseases

___ Peripheral artery disease

___ Clotting disorder

___ Rheumatoid Arthritis

___ Lupus

___ Gout

___ Other rheumatologic disease

___ Liver disease

___ Hepatitis

___ HIV/AIDS

___ Kidney Disease

___ Dialysis

___ Asthma

___ Emphysema, COPD

___ Crohn's Disease

___ Epilepsy (seizures)

___ Stroke

_____

_____

_____

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PATIENT EDUCATION

SEMAGLUTIDE

HOW DOES IT WORK?

Semaglutide mimics a natural protein found in your body called "GLP-1". This protein signals to your body that it needs to produce insulin.

Insulin helps your body take in glucose after you eat a meal,, which lowers your blood glucose levels; it can even help with weight loss.

WHO SHOULD NOT TAKE THIS MEDICATION

Talk with your doctor about your options if you have the following conditions:

- family history of medullary thyroid carcinoma (MTC)
- multiple endocrine neoplasia syndrome tpye 2 (MEN2)

WHAT IF I MISS MY DOSE?

Take a missed dose as soon as you think about it. Then, go back to your normal schedule.

If your next scheduled dose is less than 48 hours (2 days), then skip the missed dose. Do NOT take 2 doses within days of each other.

WHAT ARE THE SIDE EFFECTS?

Some common side effects: abdominal pain, constipation, diarrhea, nausea & vomiting. Most side effects can be avoided. Contact your doctor immediately if you experience any of the following symptoms: unusual swelling, wheezing or severe abdominal pain. Our product is compounded to minimize side effects.

HOW DO I TAKE THIS MEDICATION?

You need to inject the medication into a fatty part of your skin: thigh, belly, or upper arm. Rotate the site every week to avoid scarring.

You can take this with or without food. Take it the same day each week.

HOW SHOULD I TAKE THIS MEDICATION?

Store unused medicine in a refrigerator. Do NOT freeze the medication. After opening the medication can be stored in the fridge or temperature.

HOW TO ADMINISTER SEMAGLUTIDE

Choose an injection site
Side/back of arms, abdomen or the front of your thighs.

Make sure to clean and inspect your injection site.

Inject the medication

Take a big pinch of skin between your thumb and index finger and hold it.

Inject the needle into the pinched skin at a 90 degree angle. Make sure to do this quickly, but without any great force. Then withdraw needle & apply pressure to injection site.

Carefully dispose of the needle in an FDA-cleared sharps disposal container right away after use. If you do not have an container, you may use a household container you may use a household container that is made of a heavy duty plastic.

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SEMAGLUTIDE DOSING SCHEDULE

MONTH 1

WEEKS 1-4

0.25MG / 0.1CC
EACH WEEK

MONTH 2

WEEKS 5-8

0.5 MG / 02.CC
EACH WEEK

MONTH 3

WEEKS 9 - 12

1.0 MG / 0.4 CC
EACH WEEK

MONTH 4

WEEKS 13 - 16

1.7 MG / 0.7 CC
EACH WEEK

MONTH 5

WEEKS 17 AND
ONWARD

2.5MG / 1 CC
EACH WEEK

Semaglutide Injections

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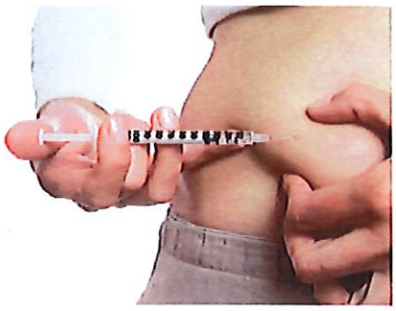
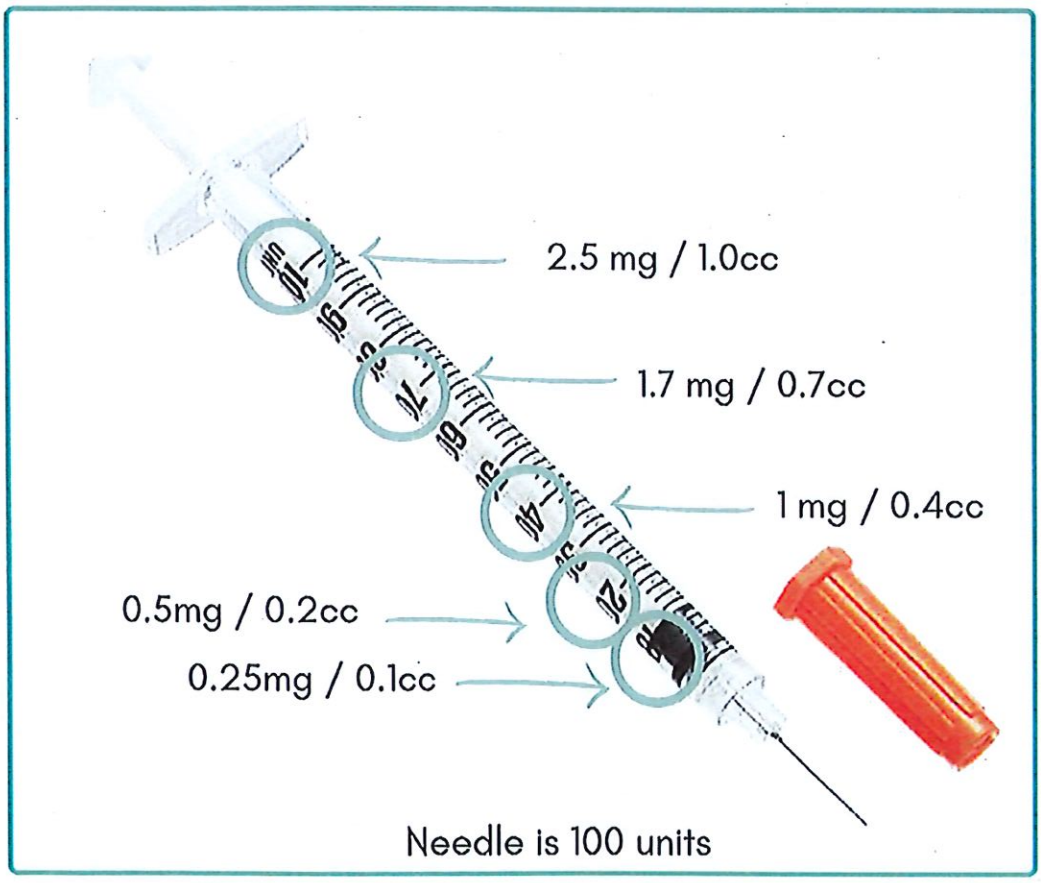
Weekly injections for Semaglutide
*Dosaging may vary from patient to patient





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Informed Consent for Use of Semaglutide for Weight Management I, _____ authorize Dr._____ to assist me in my weight reduction efforts. I understand that my treatment may involve, but is not limited to, the use of weight medications for more than 12 weeks and when indicated in higher doses than the dosage on the medication labeling. The medications provided may be provided from a compounding pharmacy, EyeRx Pharmacy in which the physician who has prescribed your medication has an ownership interest in the same pharmacy. You have the option to purchase your prescription from an alternative pharmacy including CVS, Walgreens or other local pharmacies. You will not be treated differently by your physician if you do not choose to purchase your prescription from EyeRx.

By signing here, you acknowledge that this disclosure has been made and that have read and understand this disclosure.

Patients Signature_____ Date_____

Semaglutide was originally approved for the treatment of diabetes mellitus type 2 and has also been approved to treat obesity and overweight in addition to a reduced calorie diet and increased physical activity. This medication is given by injection under the skin with an insulintype needle.

Semaglutide works by mimicking a hormone called glucagon-like-peptide-1 (GLP-1) that targets parts of the brain that regulate appetite and food intake. This medication can cause gastrointestinal side effects which may be reduced with the addition of vitamin B6 as in the EyeRxsemaglutide formulation. Side effects may be reduced by increasing the dosage gradually over 16 to 20 weeks from 0.25 mg to 2.4 mg once weekly.

Semaglutide should not be used in combination with other semaglutide-containing products, other GLP-1 receptor agonists (such as Ozempic, Trulicity, Vyctoza, Wegovy among others) other products intended for weight loss, including prescription drugs, over-the-counter drugs or herbal prodcuts. Semaglutide has not been studied in patients with a history of pancreatitis.

____ (initial here) The most common side effects of semaglutide include early satietry, descreased appetite, nausea, diarrhea, vomiting, constipation, abdominal or stomach pain, headache, fatigue, dyspepsia (indigestion), dizziness, abdominal distension, eructation (belching), hypoglycemia (low blood sugar) in patients with type 2 diabetes, flatulence (gas buildup), gastroenteritis (an intestinal infection) and gastroesophageal reflux disease.

_____ (initial here) Warning information contains a boxed warning about the potential risk of thyroid C-cell tumors. Semaglutide should not be used in patients with a personal or family history of medullary thyroid carcinoma or in patients with a rare condition called Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).

____ (initial here) Semaglutide should not be used in patients with a history of severe allergic reactions to semaglutide or any other components including vitamin B6. If allergic reaction is suspected, patients should stop semaglutide immediately and seek medical help.

____ (initial here) Semaglutide contains warnings for inflammation of the pancreas, gallbladder problems including gallstones, low blood sugar, acute kidney injury, diabetic retinopathy, increased heart rate and suicidal thinking. Patients should discuss with their healthcare professional if they have symptoms of pancreatitis or gallstones. If semaglutide is used with insulin or a substance that causes insulin secretion, patients should speak to their health care provider about potentially lowering the dose of insulin or the insulin-inducing drug to reduce the risk of low blood sugar.

Patient Name (print)	Patient Signature	Date
Dr. Melissa Toyos		
Doctor Name	Doctor Signature	Date