Bangor-Navigating Wellness Primary Care
50 Columbia Street #11, Suite 62
Bangor, ME - 04401-6331

1_NWPC WTL Intake Form 2026

Navigating Wellness Primary Care, PLLC

BANGOR: 50 Columbia Street Box #11 / Suite 62, Bangor, ME 04401

DEXTER: 24-26 Main St, Dexter, ME 04930

RENO: 3675 Lakeside Drive, Suite B, Reno, NV 89509

Phone: (407) 850-8199

Fax: (877) 284-1946

Patient Demographics

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name _____

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Fax _____

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Primary Insurance Details

Insurance Type * ☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER

Insurance Plan Name or Program Name * _____

ID * _____

Insurance Company Name (Payer Name) * _____

Payer Id *

Payer Address

Payer City

Payer Country

Payer State

Payer ZipCode

Valid From

Valid Until

Policy Group/FECA #

Copay

Deductible

Employer/School Name

Comments

Insured Person Details

Patient Relationship * ☐ Self ☐ Spouse ☐ Child ☐ Other

First Name *

Last Name *

Date of Birth *

Sex * ☐ Male ☐ Female ☐ Unknown

Address Line 1

Address Line 2

City

Country

State

Zip Code _____

Home Phone _____

Mobile Phone _____

Please complete the following with as much details as possible.

Please complete all sections of the attached form in full and do not skip any fields, as each section auto-populates directly into your medical chart. Incomplete sections may result in delays in care or require follow-up clarification. Thank you for taking the time to ensure all information is accurate and complete.

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Local Pharmacy (Location Name and Address) *

What is your current height? *

What is your current weight in pounds? *

Do you have a personal or family history of any of the following? *

- ☐ Medullary thyroid cancer
- ☐ Multiple endocrine neoplasia syndrome type 2 (MEN2)
- ☐ Pancreatitis (active or recent within 24 months)
- ☐ Gallbladder disease or gallstones
- ☐ Gastroparesis or delayed gastric emptying
- ☐ Eating disorders (anorexia, bulimia, binge eating – currently active or historical)
- ☐ Pregnancy or breastfeeding
- ☐ Active substance abuse
- ☐ Uncontrolled psychiatric illness
- ☐ Recent bariatric surgery (within 6 months)
- ☐ None

Have you been eating a healthy diet and exercising regularly? *

☐ Yes ☐ No

If the above question was yes on diet and exercise, what have you been doing?

Have you been participating in a weight management program for the last 6 months? Examples include Noom, Weight Watchers, Apple watch/iHealth, Samsung Watch, MyFitnessPal, etc. *

☐ Yes ☐ No

If the above question was yes on a management, what have you been doing?

Have you been on a GLP-1 before? (Ozempic, Rybelsus, Trulicity, Victoza, Mounjaro, semaglutide, tirzepitide, etc.) *

☐ Yes ☐ No

Do you have a family history of thyroid cancer, or endocrine neoplasia type 2? *

☐ Yes ☐ No

SECTION 3: GLP-1 Therapy Lifestyle Screening – Condensed Questions

What does a typical day of eating look like, and do you notice any patterns with cravings, late-night eating, or emotional eating? *

How often are you physically active, and do you have any limitations that affect movement or exercise? *

Do you track your food, weight, or steps? If so, how do you do it, and how consistent are you?

How many hours of sleep do you usually get, and do you feel rested in the morning? Have you been diagnosed with sleep apnea?

How would you describe your stress levels and mental health? Have you ever been diagnosed with anxiety, depression, ADHD, PTSD, or an eating disorder?

What are your goals for weight or health improvement, and how ready are you to make changes in your nutrition and activity? (Scale of 1–10)

How much weight are you looking to lose?

GLP-1 Receptor Agonist Therapy Consent & Release Form

Introduction & Purpose

I understand that I am being prescribed a GLP-1 receptor agonist (such as Wegovy, Zepbound, compounded semaglutide, or compounded tirzepatide) for the management of:

-Obesity (BMI ≥30) or overweight (BMI ≥27 with related comorbidities)

-Metabolic dysfunction-associated steatotic liver disease (MASLD)

-Obstructive sleep apnea (OSA)

-Coronary artery disease (CAD)

These medications help with weight loss by reducing appetite, slowing gastric emptying, and improving metabolic function.

Alternative Treatment Options: I understand that alternative treatments exist, including but not limited to:
- Lifestyle modification (diet, exercise, behavior therapy)
-Other prescription weight loss medications
-Bariatric surgery
- Choosing not to take any medication

Potential Risks & Side Effects: I acknowledge that GLP-1 therapy has risks, including but not limited to:

Common Side Effects: Nausea, vomiting, diarrhea, constipation, Bloating, burping, and indigestion, Delayed gastric emptying (feeling full longer than usual), Fatigue, dizziness, or mild headaches, Injection site reactions (redness, irritation, swelling).

Rare but Serious Risks: Pancreatitis – Severe abdominal pain, nausea, vomiting (requires immediate medical attention), Gallbladder disease – Signs of gallstones or cholecystitis (RUQ pain, fever, nausea), Severe dehydration – Due to persistent vomiting or diarrhea, Hypoglycemia – More common in diabetics or when combined with other glucose-lowering medications, Gastrointestinal disorders – Potential worsening of gastroparesis or severe GI distress, Thyroid tumors – I acknowledge the FDA black box warning that GLP-1 medications may increase the risk of medullary thyroid carcinoma (MTC) in certain patients. Other side effects not listed here.

I confirm that: I have no personal or family history of medullary thyroid cancer or Multiple Endocrine Neoplasia Type 2 (MEN2). I have no history of pancreatitis or active gallbladder disease. I am not pregnant, breastfeeding, or planning to conceive within the next 6 months.

Patient Responsibilities & Monitoring
I understand that GLP-1 therapy requires ongoing monitoring, and I agree to:
 Complete baseline and follow-up lab work as ordered by my provider.
 Follow scheduled check-ins to evaluate progress, side effects, and dose adjustments.
 Immediately report severe side effects such as persistent vomiting, dehydration, abdominal pain, chest pain, or signs of stroke (weakness, vision changes, speech difficulty).
 Follow provider recommendations on dose escalation to minimize side effects.
 Stay hydrated and maintain adequate nutrition while on this medication.

Financial Agreement
--I understand that GLP-1 therapy is a long-term treatment and that medications are billed on a recurring basis unless canceled per policy.

Compounded GLP-1 Pricing

Concierge Plan Patients:
--Billed monthly until discontinued by patient or provider. Must give 30-days notice.

Patients Paying Per Visit (Medicare / Medicaid, Using insurance):
--Prices vary.
--Pricing will be discussed before purchase.

I acknowledge that:
--Compounded medications are not covered by insurance.
--I am responsible for all charges associated with my GLP-1 therapy.
--I must provide 30 days' notice to cancel future shipments/billing.
--No refunds will be issued for compounded medications once shipped or prepared.

Discontinuation Criteria: I understand that my provider may discontinue treatment if: I do not lose at least 5% of my body weight within 6 months. I develop a contraindication (e.g., new thyroid cancer, pancreatitis, gallbladder disease). I experience severe or intolerable side effects. I fail to complete required lab work or follow-ups. I violate financial policies or fail to make payments.

By signing below, I acknowledge and consent to treatment with GLP-1 receptor agonists as prescribed by my provider.

PATIENT SIGNATURE *

Date *

Release of Liability – Compounded, Peptide & Off-Label Therapies

This document supplements informed consent for any compounded medications, peptides, hormones, injectables, and/or off-label therapies prescribed or coordinated by Navigating Wellness Primary Care (NWPC), including but not limited to GLP-1 receptor agonists (e.g., compounded semaglutide, tirzepatide), peptides (e.g., BPC-157, CJC-1295, ipamorelin, NAD+), hormone therapies, vitamin injections, and other non-FDA-approved uses.
Please Note: While all therapies outlined in this document may not apply to every patient, we require all patients to review and sign this acknowledgment. This ensures informed consent should any compounded, off-label, peptide, or injectable therapy become appropriate during the course of care now or in the future. Signing does not indicate that all therapies are being prescribed, only that you understand and accept the terms should they apply.

1. Understanding of Compounded Medications

I understand that: Compounded medications and peptides are custom-prepared by a compounding pharmacy and are not FDA approved for safety, efficacy, or quality. Off-label prescribing is legal and common but may lack large-scale clinical trial data for the intended use. Potency, absorption, stability, and response may vary from FDA-approved commercial products.

2. Voluntary Use and Alternatives

I confirm that I have voluntarily elected to proceed after discussion of: FDA-approved alternatives when available Non-pharmacologic options (lifestyle modification, nutrition, exercise, behavioral therapy). The risks and benefits of compounded and off-label treatment.

3. Risks Specific to Compounded Therapy

I acknowledge potential risks including, but not limited to:
Variable effectiveness or dosing
Adverse reactions or side effects
Contamination or compounding errors
Limited long-term safety data

4. Patient Acknowledgment of Responsibility

I agree to:
Use only medications sourced through a provider-approved pharmacy
Follow prescribed storage, handling, and administration instructions
Promptly report side effects or concerns
Not share or distribute medications

I understand these therapies are provided “as-is” without guarantees, and I release NWPC, its providers, staff, and affiliated pharmacies from liability related to:
Adverse effects or lack of desired results
Improper storage or administration outside provider control

5. Financial and Regulatory Considerations

I acknowledge that:
Compounded and off-label therapies are cash-pay only and not insurance-covered
I am financially responsible once medication preparation begins
No refunds are issued once dispensed
Availability and shipping are not guaranteed

6. Indemnification and Hold Harmless Clause

I agree to hold harmless and indemnify Navigating Wellness Primary Care, its providers, employees, and agents from any claims arising from my decision to pursue compounded, peptide, hormone, or off-label therapies, including regulatory or pharmacy-related issues.

PATIENT SIGNATURE *

Date *

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?

Person 1 - Provide: Name, Relationship and Contact Number

Person 2 - Provide: Name, Relationship and Contact Number

Person 3- Provide: Name, Relationship and Contact Number

Patient may revoke/modify this specific authorization and that revocation/modification must be in writing.

HIPAA NOTICE OF PRIVACY PRACTICES

Please review this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Use as required by law

Release of Information. I hereby permit practice and the physicians or other health professionals involved in the outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

● Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

● If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports.

● Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Consent to Care

I understand that by signing this agreement, I consent to all general outpatient medical care, dental care and or routine outpatient services, including evaluation, therapies, nursing care and diagnostic testing provided under the general or specific instruction of my physician(s) and other health care providers. I understand that my physician(s) or other health care providers may be accompanied and/or assisted by students, interns, and residents during my care. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my physician(s) or other authorized health care providers.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at the email or text address from the practice.

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

-- The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is the number you placed on file.

-- The email that I authorized to receive email messages for appointment reminders, feedback, and general health reminders/information is the email I placed on tile.

-- The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Prescription Order Pick-Up

There may be times when you need a friend or family member to pick up a prescription order (script) from your physician’s office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

I wish to designate the following family member/friend to pick up and order on my behalf: (Leave blank if you do not wish to designate a person)

Name of designee

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I acknowledge that I have reviewed the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Expiration of Authorization

I understand that this authorization will remain in effect for one year from the date signed, or until I submit a written revocation.

I understand that:

- I have the right to revoke this authorization at any time by submitting a written request to Navigating Wellness Primary Care PLLC (NWPC). This revocation will take effect upon receipt of my written request and will not affect any actions taken prior to that time.
- Revoking this authorization may impact NWPC's ability to bill my insurance for services rendered. I understand that if I choose to revoke this authorization, I may be personally responsible for covering the costs associated with my care.
- I am not required to sign this authorization to receive treatment at NWPC. My decision to sign or not sign this authorization will have no impact on the quality of care I receive or my ability to access services.
- I have the right to receive a copy of this authorization for my records.

PATIENT SIGNATURE *

Date *

Policy on Late Charges, No-Show Fees, and Insufficient Funds

Effective Date: 12/29/2025

Late Charge Policy

Policy: To encourage timely payments and ensure smooth financial operations, a late charge fee will be applied to overdue balances.

Fee Amount: $50

Grace Period: Payments must be received by the 10th of each month. A $50 late charge will be added to accounts with outstanding balances if payment is not received by this date.

TIER Services and Products: This fee is added to the monthly services rendered if the payment deadline is missed.

No-Show Policy

Policy: To handle missed appointments and improve scheduling efficiency, a no-show fee will be applied for any appointments missed without prior notice. --Three (3) consecutive no-shows or cancellations, without valid circumstances, will result in termination from the practice. -- Missed first visit with Medicare or Medicaid, the patient will not be rebooked. Fee Amount: $75 Notice Requirement: Patients must provide a minimum of 24 hours' notice to cancel or reschedule an appointment. Failure to do so will result in the no-show fee. ¨ Application: This fee is charged for appointments missed without proper notice

Exceptions to No-Show Policy

Medical Emergencies: No-show fees will be waived for appointments missed due to unforeseen medical emergencies. Documentation may be required.
Severe Weather or Travel Issues: Fees may be waived in cases of severe weather or significant travel disruptions, provided that notice is given as soon as possible.
Administrative Errors: Fees will not be charged if the no-show is due to an administrative error on our part.

Insufficient Funds Policy

Policy: A $45 fee will be charged to the account for payments returned due to insufficient funds, whether by check, credit card, debit card, or other forms of payment.
Fee Amount: $45
Application: This fee is applied to any payment returned due to insufficient funds.

Service Cancellation Due to Non-Payment

Policy: To manage overdue accounts and ensure financial stability, services will be canceled if payment remains unresolved.
Cancellation Condition: If an account remains unpaid for more than two consecutive months, all services will be suspended until the outstanding balance is cleared.
Reinstatement: Services will be reinstated once the full balance, including any applicable late charges, is paid

Collections Policy

Policy: To recover outstanding balances and manage financial risk, overdue accounts that remain unresolved after 90 days will be referred to a collection agency.
Referral to Collections: Accounts that are more than 90 days past due will be turned over to a collection agency for further action.
Notification: Patients will be notified by email, phone, or mail before the referral to collections.

HeathInfo Net

Navigating Wellness Primary Care is excited to announce our participation in the statewide Health Information Exchange (HIE). Managed by an independent nonprofit, HealthInfoNet, the HIE is a secure computer system that will help us share your important health information, such as registration data, visits, allergies, conditions and diagnoses, test results, and reports with other healthcare providers across the state to help improve how we deliver care to you.
The key to HealthInfoNet's system is that it links your clinical information from unaffiliated healthcare organizations to create a single, secure electronic health record. Having access to this system will give our staff more of the information they need to make the best decisions possible when treating you, especially in situations when waiting for a fax or an email is often out of the question.
Your personal health information and privacy is very important to us. HealthInfoNet takes many precautions to keep your records secure. For instance, your HealthInfoNet record can only be viewed by those involved in your care and wellness.
While we believe the use of systems like HealthInfoNet will improve the care you receive, you can choose to opt-out and have your health information removed from HealthInfoNet by filling out the General Medical Opt-Out form (attached or found online https://map.hinfonet.org:8443/patientoptions/optout). If you choose to opt-out from HealthInfoNet, your medical information will NOT be available to participating providers, even in the case of an emergency.
(Note: For printed consent forms, you can mail them to HealthInfoNet at the following mailing address: Auburn Hall Suite 305, 60 Pineland Drive, New Gloucester, ME 04260 or by calling 207-541-9250 (local) 1-866-592-4352 (toll free).
If you have any questions about this exciting partnership, please do not hesitate to contact Jessica Redmond (407) 850-8199 or visit www.hinfonet.org for more information.

Patient Acknowledgment

By signing below, you acknowledge that you have read, understood, and agree to the terms outlined in this policy, including the fees for late payments, no-shows, insufficient funds, service cancellation for non-payment, and the referral to collections for overdue accounts. You also acknowledge that a $50 late charge will be applied the day after the 10th of each month for overdue balances on non-covered services and cash-pay accounts.

PATIENT SIGNATURE *

Date