# Medical Intake Summary

Submission ID: patricia-test-1763819760130

## Patient Profile

PATIENT
Patricia Altamirano

DOB
05/10/1964

GENDER
Female

PHONE
5126639552

EMAIL
uribepa@yahoo.com

ADDRESS
7610 Compass Dr
Austin, TX 78724

### MOTIVATION & CONSENT

| | |
|---|---|
| How would your life change by losing weight? | Enjoying how your clothes fit, Having more confidence, Getting your energy back, Feeling better about yourself, Improving your overall health |
| Marketing Consent | [X] Yes |

### VITALS & GOALS

| | |
|---|---|
| Ideal Weight | 150 |
| Starting Weight | 190 |
| BMI | 31.61 |

## VITALS & GOALS (CONT.)

| | |
|---|---|
| Pounds to Lose | 40.00 |

## LIFESTYLE & ACTIVITY

| | |
|---|---|
| Daily Physical Activity | 3-Moderate |

## MEDICAL & MENTAL HEALTH HISTORY

| | |
|---|---|
| Chronic Illness | No |
| Type 2 Diabetes | No |
| Pregnant or Breastfeeding | No |
| Blood Pressure | 120-129/less than 80 |

## REFERRAL SOURCE

| | |
|---|---|
| How did you hear about us? | Facebook |

## ADDITIONAL RESPONSES

| | |
|---|---|
| First Name | Patricia |
| Last Name | Altamirano |
| Email | uribepa@yahoo.com |
| Phone | 5126639552 |
| Date of Birth | 05/10/1964 |
| Gender | Female |

## ADDITIONAL RESPONSES (CONT.)

| | |
|---|---|
| Street Address | 7610 Compass Dr |
| City | Austin |
| State | TX |
| ZIP Code | 78724 |
| Select the state you live in | Texas |
| By clicking this box, I acknowledge | [X] Yes |

## Legal Disclosures & Consents

• Privacy Policy & HIPAA Compliance: I understand my health data is stored securely in accordance with HIPAA regulations and will be used solely for treatment coordination. I acknowledge that my protected health information (PHI) will be shared only with authorized healthcare providers and pharmacy partners involved in my care.

• Weight-Loss Treatment Consent: I authorize EONMEDS and its affiliated medical professionals to review my intake form, laboratory results, vital signs, and medical history to determine candidacy for GLP-1 receptor agonists and adjunct therapies. I understand that treatment recommendations are based on medical evaluation and may be modified or discontinued based on clinical response.

• Telehealth Services Agreement: I consent to receive healthcare services via telehealth technology and understand that these services are subject to the same standards of care as in-person visits. I acknowledge that technical issues may occasionally affect service delivery and that alternative arrangements will be made when necessary.

• Financial Responsibility & Cancellation Policy: I understand that cancellations or rescheduling within 24 hours of scheduled appointments may incur fees up to the full consultation cost. I acknowledge responsibility for all charges not covered by insurance and agree to the payment terms outlined in the financial agreement.

• Informed Consent & Risk Acknowledgment: I have been informed of the potential risks, benefits, and alternatives to GLP-1 therapy. I understand that individual results may vary and that no specific outcome is guaranteed. I agree to report any adverse effects immediately to my healthcare provider.

Digitally signed by
**Patricia Altamirano**
11/22/2025, 8:56:01 AM
Submission ID: patricia-test-1763819760130