NurseLink

COMPLETE TELEHEALTH PATIENT FORMS PACKET

Patient privacy Return completed forms only through NurseLink's approved secure portal or health-record workflow. Do not send protected health information through ordinary email unless NurseLink has specifically provided an approved secure method.

Patient full legal name:

Date of birth:

Packet completion date:

Packet contents

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Practice use Before use, NurseLink should insert its legal entity name, contact information, prices, state-specific notices, and clinician-specific protocols. Counsel and the treating clinician should approve consent language. This packet is a customizable operational template, not legal advice or a substitute for clinical judgment.

FORM 01

Patient Registration

Please complete all applicable fields. Write "N/A" when a question does not apply.

Patient information

Full legal name:

Preferred name:

Date of birth	Gender		

Street address:

State where you will be physically located during your telehealth visit

City	State	ZIP

Mobile phone	Alternate phone	Email

Preferred language ☐ English ☐ Spanish ☐ Other:

Emergency contact

Name	Relationship	Phone

Care information

Primary care clinician / practice:

Preferred pharmacy name and location:

Pharmacy phone:

Billing and responsible party

Payment relationship ☐ Self ☐ Parent/guardian ☐ Other:

Responsible party name (if different):

Billing address (if different):

How did you hear about NurseLink? ☐ Search ☐ Referral ☐ Social media ☐ Other:

I certify that the information provided is true and complete, and that I am responsible for notifying NurseLink Clinic of any changes.

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 02

Comprehensive Medical History

Please complete all applicable fields. Write "N/A" when a question does not apply.

Current concerns

Primary reason for visit:

Symptoms, onset, severity, and what makes them better or worse:

Health goals for this visit:

Medical conditions

Check all that apply	Details / date diagnosed
☐ High blood pressure	
☐ High cholesterol	
☐ Diabetes / prediabetes	
☐ Heart disease	
☐ Stroke / TIA	
☐ Blood clot / clotting disorder	
☐ Asthma / COPD	
☐ Sleep apnea	
☐ Kidney disease	
☐ Liver / gallbladder disease	
☐ Thyroid disease	
☐ Seizure disorder	
☐ Cancer	
☐ Depression	
☐ Anxiety	
☐ Eating disorder	
☐ Migraine	
☐ GERD / ulcer	
☐ Pancreatitis	
☐ Glaucoma	
☐ Other:	

Past care

Surgeries / hospitalizations	Reason	Year

Significant injuries / illnesses	Details / date

Family history

Condition	Relative(s)	Approx. age at diagnosis
Heart disease / early heart attack		
Stroke		
Diabetes		
High blood pressure		
Cancer (type: _____)		
Thyroid disease		
Other:		

Social and preventive history

Tobacco / nicotine ☐ Never ☐ Former ☐ Current

Type, amount, years, quit date (if applicable):

Alcohol ☐ None ☐ Monthly or less ☐ 2–4 times/month ☐ 2–3 times/week ☐ 4+ times/week

Typical drinks per occasion:

Cannabis or non-prescribed substances ☐ No ☐ Yes — describe:

Occupation and work schedule:

Living situation / safety concerns:

Last routine physical and preventive screenings:

Additional health (if applicable)

Last menstrual period:

Could you be pregnant? ☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Breastfeeding? ☐ No ☐ Yes ☐ Not applicable

Contraception / pregnancy plans:

Do you have an advance directive? ☐ No ☐ Yes ☐ Prefer not to answer

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 03

HIPAA Notice of Privacy Practices Acknowledgment

This form acknowledges receipt of NurseLink's Notice of Privacy Practices. It is not an authorization to disclose records.

Important NurseLink must provide its current Notice of Privacy Practices separately. Ask questions before signing. Refusal to sign does not by itself prevent treatment, although NurseLink may document its good-faith effort to obtain acknowledgment.

I acknowledge that:

- I received or was offered access to NurseLink's Notice of Privacy Practices.
- The Notice explains permitted uses and disclosures of my protected health information, my privacy rights, and how to submit a complaint.
- NurseLink may revise the Notice as permitted by law, and the current version will be available through the practice.
- I may request restrictions or alternative confidential communications; NurseLink will explain which requests it can accommodate.

How was the Notice provided? ☐ Paper copy ☐ Electronic copy / link ☐ Offered; declined copy

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

I acknowledge that I've received or been offered a copy of NurseLink Clinic's Notice of Privacy Practices._____

For practice use only

Acknowledgment obtained? ☐ Yes ☐ No

If not obtained, describe good-faith effort and reason:

Staff name / initials:

Date:

FORM 04

Consent to Telehealth Services

Please complete all applicable fields. Write "N/A" when a question does not apply.

Emergency warning Telehealth is not an emergency service. For severe or life-threatening symptoms, call 911 or go to the nearest emergency department. If the video connection fails during an urgent situation, follow the clinician's emergency instructions.

Nature of telehealth

Telehealth uses electronic audio, video, messaging, remote monitoring, or related technology to provide health services when patient and clinician are in different locations.

Potential benefits

Convenient access, reduced travel, continuity of care, and timely clinical communication.

Material risks and limitations

Technology or connection failure; privacy or security breach despite safeguards; incomplete information without an in-person examination; diagnostic or treatment limitations; delays in care; and the need for in-person evaluation, testing, urgent care, or emergency services.

Privacy and participation

Reasonable privacy and security safeguards will be used. I will participate from a private location when possible, identify anyone present, and not record a visit unless everyone has agreed and recording is lawful.

Clinical judgment and alternatives

The clinician may determine telehealth is inappropriate and recommend in-person care. Alternatives include in-person care, urgent care, emergency care, or another qualified provider. Results are not guaranteed.

Prescribing and follow-up

Prescriptions, refills, testing, referrals, and follow-up depend on clinical appropriateness and applicable law. A telehealth visit does not guarantee a prescription.

Location and backup plan

Physical location at time of visit (street/city/state):

Callback phone:

Local emergency contact name / phone:

Consent: I have read and understand this form, had an opportunity to ask questions, and voluntarily consent to telehealth services. I may withdraw consent prospectively by notifying NurseLink, subject to care already provided and legal requirements.

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 05

Financial Policy

Please complete all applicable fields. Write "N/A" when a question does not apply.

Complete before use Practice must insert current fees, accepted payment methods, refund terms, and state-specific requirements. Give the patient a completed copy.

Policy item	NurseLink terms
Visit / service fees	Current fees displayed before booking
Payment timing	Due: At booking.
Accepted payment methods	Credit cards and debit cards only.
Cancellation window	Cancel or reschedule at least 24 hours before appointment.
Late cancellation fee	$25.00
No-show fee	$25.00
Late arrival	If you arrive more than 10 minutes late, visit may be shortened or rescheduled; applicable fee may apply.
Refunds	Refunds are not provided to completed medical services. Billing issues will be reviewed.
Labs, imaging, pharmacy, and outside services	Unless stated otherwise, outside charges are separate and paid directly to the outside provider.
Insurance / reimbursement	NurseLink is cash-pay and does not bill insurance.
Payment disputes	Please contact NurseLink Clinic at hello@nurselinkclinic com before initiating a payment dispute so the practice can review the concern.

Patient responsibility: I understand the fees outlined in this policy, I authorize payment for requested services, and accept responsibility for charges not paid by another party. Clinical outcomes and prescriptions are not guaranteed, and fees compensate the practice for professional services rendered.

Would you like a receipt / superbill if available? ☐ No ☐ Yes

I agree to this financial policy

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 06

Medication & Allergy List

Bring this list to every visit and update it whenever anything changes.

Are you currently taking any medications, vitamins, herbs, injections, or non-prescription products? ☐ No ☐ Yes — list below

Medication / product	Strength	Dose & route	Frequency	Reason	Prescriber

Allergies and adverse reactions

Known medication or substance allergies? ☐ No known allergies ☐ Yes — list below

Medication / food / substance	Reaction and severity	Approx. date	Was emergency care needed?

Medication safety

Do you use more than one pharmacy? ☐ No ☐ Yes

Any trouble taking medications as directed? ☐ No ☐ Yes — explain:

Any recent medication changes or side effects? ☐ No ☐ Yes — explain:

Preferred pharmacy and phone:

Last updated by / date:

FORM 07

Review of Systems

Check symptoms you currently have or have experienced recently. Explain significant "Yes" answers.

System	No	Yes	Symptoms / details
General	☐	☐	Fever, chills, fatigue, unexpected weight change
Eyes	☐	☐	Vision change, eye pain, redness
Ear / nose / throat	☐	☐	Hearing change, congestion, sore throat, trouble swallowing
Cardiovascular	☐	☐	Chest pain, palpitations, fainting, swelling
Respiratory	☐	☐	Cough, wheezing, shortness of breath
Gastrointestinal	☐	☐	Nausea, vomiting, abdominal pain, reflux, diarrhea, constipation, blood in stool
Genitourinary	☐	☐	Painful urination, frequency, blood in urine, discharge
Musculoskeletal	☐	☐	Joint pain, muscle pain, weakness, back pain
Skin	☐	☐	Rash, itching, changing lesion
Neurologic	☐	☐	Headache, dizziness, numbness, weakness, seizure
Psychiatric	☐	☐	Depressed mood, anxiety, sleep change, thoughts of self-harm
Endocrine	☐	☐	Heat/cold intolerance, excessive thirst/urination
Hematologic	☐	☐	Easy bruising, bleeding, swollen nodes
Allergic / immune	☐	☐	Seasonal allergies, recurrent infection, swelling

Additional details, duration, or severity:

Urgent symptoms Call 911 for severe chest pain, severe trouble breathing, stroke symptoms, loss of consciousness, or imminent risk of harm. Do not wait for a portal response.

FORM 08

Weight Loss Intake

Please complete all applicable fields. Write "N/A" when a question does not apply.

Measurements and goals

Current weight	Height	Waist	Highest adult weight	Lowest adult weight	Goal weight

Weight timeline and desired pace / goal:

Prior efforts

Program / medication / procedure	Dates / duration	Weight change	Benefits, side effects, reason stopped

Lifestyle

Typical meals, snacks, beverages, and water intake:

Physical activity type / frequency:

Sleep hours / quality:

Stress level and major stressors:

Eating patterns ☐ Emotional eating ☐ Binge episodes ☐ Night eating ☐ Restrictive eating ☐ Purging ☐ None

Food insecurity, cultural needs, or dietary restrictions:

Safety screening

Condition / risk	No	Yes / Unsure — explain
Pregnant, trying to conceive, or breastfeeding	☐	☐
Personal or family history of medullary thyroid carcinoma	☐	☐
Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)	☐	☐
History of pancreatitis	☐	☐
Severe gastroparesis or serious gastrointestinal disease	☐	☐
Gallstones / gallbladder disease	☐	☐
Kidney disease or dehydration episodes	☐	☐
Diabetic retinopathy	☐	☐
Type 1 diabetes	☐	☐
Current insulin or sulfonylurea use	☐	☐

Condition / risk	No	Yes / Unsure — explain
Eating disorder history or current symptoms	☐	☐
Mental health condition or symptoms that may affect the safety or weight-management treatment.	☐	☐
Planned surgery / anesthesia	☐	☐
Prior allergic reaction to a GLP-1 or related medication	☐	☐

Recent labs, diagnoses, or clinician concerns:

Are you willing to use contraception and avoid pregnancy during treatment if applicable? ☐ Yes ☐ No ☐ Not applicable

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 09

GLP-1 Medication Informed Consent

For treatment with a prescribed GLP-1 receptor agonist or related incretin-based medication. This consent supplements medication-specific counseling and labeling.

Medication to be considered Name: _____ Dose/plan: _____ ☐ FDA-approved use ☐ Off-label use explained by clinician

Purpose and expectations

These medicines may support chronic weight management and/or diabetes care when clinically appropriate, together with nutrition, activity, sleep, and follow-up. Response varies; weight regain may occur after stopping.

Common effects

Nausea, vomiting, diarrhea, constipation, abdominal discomfort, reflux, reduced appetite, headache, fatigue, and injection-site reactions may occur, especially during dose changes.

Serious or clinically important risks

Potential risks include pancreatitis, gallbladder disease, dehydration and kidney injury, severe gastrointestinal symptoms or delayed stomach emptying, low blood sugar when combined with certain diabetes medicines, allergic reactions, and worsening diabetic retinopathy in some patients. Product-specific risks and warnings may differ.

Thyroid tumor warning / contraindications

Certain products carry a boxed warning based on thyroid C-cell tumors in rodents and are contraindicated with a personal or family history of medullary thyroid carcinoma or MEN 2. I will report a neck mass, hoarseness, trouble swallowing, or persistent throat symptoms.

Pregnancy, procedures, and other medicines

Weight-loss treatment is not used during pregnancy. I will notify NurseLink immediately about pregnancy, pregnancy plans, breastfeeding, planned surgery/anesthesia, or new medicines. Delayed stomach emptying may affect oral medicines; product-specific contraception advice may apply.

Dosing and sourcing

I will use only the prescribed dose and schedule, will not share medication, and will follow storage and missed-dose instructions. If a compounded product is proposed, the clinician will separately explain that compounded drugs are not FDA-approved and discuss source, quality, alternatives, and applicable requirements.

Monitoring and stopping

I agree to recommended follow-up, labs, and monitoring. I will seek urgent care for severe or persistent abdominal pain, repeated vomiting, inability to keep fluids down, signs of severe allergy, severe low blood sugar, or other alarming symptoms. The clinician may pause or stop treatment for safety, lack of benefit, pregnancy, or missed monitoring.

I confirm that I have disclosed ☐ All medical conditions ☐ All medications/supplements ☐ Allergies ☐ Pregnancy status/plans ☐ Relevant family history

Consent: I understand the expected benefits, material risks, alternatives (including lifestyle care, other medications, referral, or no medication), monitoring plan, and that no result is guaranteed. I had the opportunity to ask questions and voluntarily consent to the treatment plan documented above.

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

Clinician signature / credentials:

Date / time:

FORM 10

Authorization for Release of Health Information

Complete one authorization per person or organization. This authorization is voluntary and may be revoked prospectively in writing, except to the extent already relied upon.

Patient

Patient full name:

Date of birth	Phone	Address

Release direction

I authorize NurseLink to ☐ Send records to ☐ Obtain records from ☐ Exchange records with

Person / organization	Address	Phone	Fax / secure contact

Information and purpose

Records to disclose ☐ Complete record ☐ Visit notes ☐ Medication list ☐ Lab / imaging results ☐ Billing records ☐ Other:

Date range: From **to**

Purpose ☐ Continuity of care ☐ At my request ☐ Legal ☐ Insurance / benefits ☐ Other:

Include specially protected information, if present and permitted by law? ☐ Behavioral health ☐ Substance use disorder records ☐ HIV / STI information ☐ Genetic information ☐ Do not include

Special authorization Some records require additional language or a separate authorization under federal or state law. NurseLink will use the authorization required for the record type and jurisdiction. Information disclosed to a recipient may be subject to redisclosure unless protected by law.

Expiration and revocation

This authorization expires ☐ On: ☐ When this event occurs: ☐ As otherwise permitted by law

Send written revocation to NurseLink at:

I understand that treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing this authorization except as permitted by law.

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 11

Communication Consent & Preferences

Choose how NurseLink may contact you. Electronic communication can carry privacy risks. Do not use routine messaging for emergencies.

Channel	Allow?	Permitted content / limits
Patient portal	☐ Yes ☐ No	Appointments, clinical messages, forms, results
Phone call	☐ Yes ☐ No	Number:
Voicemail	☐ Yes ☐ No	☐ Detailed ☐ Callback request only ☐ No voicemail
Text / SMS	☐ Yes ☐ No	☐ Scheduling ☐ Billing ☐ General care reminders ☐ Other:
Email	☐ Yes ☐ No	☐ Scheduling ☐ Billing ☐ General care reminders ☐ Other:

Approved mobile number:

Approved email address:

People NurseLink may speak with (name, relationship, permitted topics):

May NurseLink identify itself by name in a message? ☐ Yes ☐ No — use generic callback request

Preferred contact method ☐ Portal ☐ Phone ☐ Text ☐ Email

Do-not-contact times or other restrictions:

Communication risks Standard text and email may be unencrypted, may appear on shared devices, and may be accessed by others. Carrier/data fees may apply. Consent is optional and may be changed prospectively by notifying NurseLink. NurseLink may still communicate as permitted or required by law.

Consent: I authorize the communication methods and limits selected above and accept the described risks. I will keep my contact information current and use emergency services—not routine messages—for urgent or life-threatening concerns.

Signature	Printed name	Date / Time

If signed by representative, relationship and authority:

FORM 12

Patient Satisfaction Survey

Thank you for helping NurseLink improve. You may omit your name unless follow-up is requested.

Please rate your experience	1 Poor	2	3	4	5 Excellent	N/A
Ease of scheduling	☐	☐	☐	☐	☐	☐
Clarity of pre-visit instructions	☐	☐	☐	☐	☐	☐
Technology / connection experience	☐	☐	☐	☐	☐	☐
Clinician listened and understood my concerns	☐	☐	☐	☐	☐	☐
Explanations were clear	☐	☐	☐	☐	☐	☐
I participated in care decisions	☐	☐	☐	☐	☐	☐
Privacy and professionalism	☐	☐	☐	☐	☐	☐
Clarity of follow-up plan	☐	☐	☐	☐	☐	☐
Overall experience	☐	☐	☐	☐	☐	☐

Would you recommend NurseLink? ☐ Definitely not ☐ Probably not ☐ Unsure ☐ Probably ☐ Definitely

What went well?

What could we improve?

Additional comments:

May NurseLink contact you about this feedback? ☐ No ☐ Yes

Name (optional):

Preferred contact:

Privacy Do not include urgent medical questions in this survey. Use the patient portal or call NurseLink for care questions; use emergency services for emergencies.