Platinum Wellness Center, LLC
"Opening the Door to the Future of Healthcare"
Jamey Hagan MSN, NP-C, CEO

platinumwellnesscenter.org
Office Number: 931-292-6377
Office Fax: 931-292-6389

PATIENT DEMOGRAPHICS

FIRST NAME: _____ **MIDDLE NAME:** _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____ **SSN:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE #: _____ **CELL PHONE #:** _____

EMAIL ADDRESS: _____

WORK STATUS: _____ **EMPLOYER:** _____ **WORK PHONE:** _____

MARRIED: YES ____ NO ____ **IS YOUR SPOUSE OR PARENT A MEMBER?** YES ____ NO ____

SPOUSE OR PARENT'S NAME: _____ **RELATION:** _____

EMERGENCY CONTACT: _____ **CONTACT'S PHONE #:** _____

WHO REFERRED YOU TO US? _____

The above information is true to the best of my knowledge. I understand that Platinum Wellness Center, LLC does not accept any insurance plans, therefore by signing this document, I understand that I am fully financially responsible for my monthly membership fees or other expenses acquired during an office visit, whichever may apply. I also understand any services not included in the membership should be paid in full before services are rendered.

_____ _____

Signature Date

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CONSENT FOR TREATMENT

I, _____, hereby authorize Jamey Hagan MSN, NP-C, CEO and whomever he may suitable designate to administer necessary medical care.

_____ _____
Printed Name Date of Birth

_____ _____
Signature Date

_____
Witnesses Printed Name

_____
Witnesses Signature

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Medical History

What brings you to Platinum Wellness Center? _____

Please list all allergies (food, medicine, and other): _____

_____

Please list all medications you are currently taking: _____

_____

Please list all surgeries / procedures you have had: _____

_____

Do you currently have, or have you had, any of the following conditions?

☐ Abnormal EKG	☐ Diarrhea	☐ Irritable Bowel Syndrome	☐ Recent Flu Vaccine
☐ Acid Reflux	☐ Emphysema or COPD	☐ Kidney Disease	☐ Recent Pneumonia Vaccine
☐ Acne	☐ Epilepsy or Seizures	☐ Kidney Stones	☐ Rheumatoid Arthritis
☐ ADD/ADHD	☐ Erectile Dysfunction	☐ Lyme Disease	☐ Shortness of Breath
☐ Anemia	☐ Eye Problems	☐ Melanoma	☐ Sickle Cell Disease
☐ Anxiety	☐ Gallbladder Disease	☐ Memory Loss	☐ Sinus Problems
☐ Asthma	☐ Gardasil Series	☐ Migraines	☐ Skin Disorders
☐ Blood Clots	☐ Gout	☐ MTHFR	☐ Snoring
☐ Cancer	☐ Headaches	☐ Neck or Spinal Issues	☐ STD
☐ Chest Pain	☐ Hearing Loss	☐ Normal TB Screening	☐ Stroke
☐ Chick Pox or the Vaccine	☐ Heart Attack	☐ Obstructive Sleep Apnea	☐ Suicidal Thoughts or Attempts
☐ Concussion	☐ Heart Disease	☐ OCD	☐ Tetanus Vaccine
☐ Constipation	☐ Hepatitis B Series	☐ Osteoarthritis	☐ Thyroid Disease
☐ Crohn's Disease	☐ Hernia	☐ Pancreatitis	☐ Ulcerative Colitis
☐ Depression	☐ High Blood Pressure	☐ Peripheral Vascular Disease	☐ Urinary Incontinence
☐ Diabetes	☐ High Cholesterol	☐ Psoriasis	☐ Urinary Infections

Are you allergic to any of the following?

Sulfates	☐ Yes	☐ No
Zofran	☐ Yes	☐ No

GYN History (Women Only)

Age of first Menses: _____

Regular Periods	☐ Yes	☐ No
Painful Periods	☐ Yes	☐ No
PMS Symptoms	☐ Yes	☐ No
Menopause	☐ Yes	☐ No
Abnormal Pap	☐ Yes	☐ No
Pain with Intercourse	☐ Yes	☐ No
Content with Sex Life	☐ Yes	☐ No

OB History (Women Only)

Abortions	☐ Yes	☐ No
If yes, how many? _____		
Full-term Pregnancies	☐ Yes	☐ No
If yes, how many? _____		
Infertility Issues	☐ Yes	☐ No
Miscarriages	☐ Yes	☐ No
If yes, how many? _____		
Preterm	☐ Yes	☐ No

Total Number of Pregnancies: _____

Social History

Occupation: _____

Do you smoke/use tobacco? ☐ Yes ☐ No

If yes, how much per day and for how long? _____

Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If so, how often? _____

Do you consume caffeine? ☐ Yes ☐ No

If so, how much and how often?

_____

Do you use recreational drugs? ☐ Yes ☐ No

Special diet? ☐ Yes ☐ No

Regular exercise? ☐ Yes ☐ No

Sexually active? ☐ Yes ☐ No

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HIPAA Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy is available for your review at the front desk.

The patient understands that:

1. We will not release information to any future doctor, attorney, life insurance company, or workmen's comp company without your written consent.
2. Protected health information may be used for treatment through one of your current doctors such as your primary care physician or a specialist referral, payment with your insurance company, or healthcare operations within our practice.
3. Platinum Wellness Center, LLC has a notice of privacy practices that is available for review.
4. Platinum Wellness Center, LLC reserves the right to change the notice on privacy practices.
5. The patient has the right to restrict the use of their information, but Platinum Wellness Center, LLC does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality healthcare.
6. The patients may revoke this consent, in writing, at any time, and all future disclosures will then cease.
7. Platinum Wellness Center, LLC may condition treatment upon the execution of this consent, for example, you may be required to pay for your visit at the time of service.

By signing this form, you consent to our use and disclosure of protected health information according to the notice of privacy practices. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Platinum Wellness Center, LLC provides this form to comply with the health insurance portability and accountability act of 1996 (HIPAA). You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. This request must be made in writing. Whenever possible, we will honor your request.

_____ _____

Patient or Patient's Representative's Signature Date

I waive my rights of disclosures for the practice to speak with the following people about my treatment:

_____ _____

Printed Name Phone Number

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Membership Agreement

This agreement describes the terms and conditions of a membership established at Platinum Wellness Center.

1. Membership Benefits: Platinum Wellness Center provides integrative, functional care for adults and children that are members. There are several other membership benefits. Please ask for details.
2. Monthly or Annual Fees: Cash, Debit, or Credit Cards are the preferred payment methods. With NO exceptions, a card must be on file in order to obtain a membership at Platinum Wellness Center. An auto-draft of your membership fee can be performed on the 1st, 5th, 10th, 15th, 20th, or 25th of each month. Others may prefer to pay for a full year all at once with a HAS or even income tax returns. There will be no services provided before payment is received. Prices are subject to change and will be based on rising costs for supplies and compounding pharmacy expenses. However, we will always try to keep the total cost as low as possible. Membership costs are as follows:
   Individual Adults: $100 per month via auto draft. Spouses receive a $25 per month discount.
   Individual Children: $10 per month per child. One parent must have an established membership.

Patient Name: _____ Membership Fee: _____

Spouse's Name: _____ Membership Fee: _____

Child's Name: _____ Membership Fee: _____

*** IT IS YOUR RESPONSIBILITY TO CANCEL YOUR MEMBERSHIP WHEN IT IS NO LONGER WARRANTED. ***

Healthcare services excluded from membership fee: Your membership fee does not include any form of ozone administration, intravenous mineral treatments, nutrients, vitamin replacement therapy, or supplements from Standard Enzyme, Xymogen, LiveOn Labs, or any of our main supplement lines. Chelation, intravenous Vitamin C, Electrodermal testing, lymphatic treatments, and emotional release are also not covered by your monthly membership. All these additional services are provided to you at a fair and reasonable cost based on other naturopathic clinics pricing across the nation. Your membership will include unlimited office visits with no co-pays or deductibles, access to alternative therapies that are healing in nature, contracted or negotiated lab and radiology costs, and access to the highest quality supplements in the nation. Let it be noted that Xymogen and Standard Enzyme supplements cannot be purchased by the regular consumer. The supplements can only be purchased through this office or another licensed provider that is contracted with these companies. Your membership also includes a 25% discount to any spouse who wishes to join Platinum Wellness Center as a member to achieve the ultimate health status. Any child typically between the ages of 5 to 17 years of age may join with one active parent membership.

Platinum Wellness Center nor Jamey Hagan will serve as your Primary Care Physician. It is solely your responsibility to establish or maintain a Primary Care Physician.

_____ _____

Patient Signature Date

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Hair and Saliva Sample Collection

General Guidelines Before Starting Collection:

- The scissors or razor selected to collect hair need to be cleaned with alcohol prior to use. They cannot have had contact with any other hair.
- Before collection, your hair needs to be clean and dry, containing no hair products of any kind.
- Do not put anything in your mouth 30 minutes prior to collecting your saliva.
- Hair and Q-Tips containing your saliva can be placed within the same Ziplock bag together. There is no need for separation.
- Please make sure to wash your hands thoroughly before continuing with collection.

Hair Collection:

- Hair can be taken from any part of your body as long as it is as close to the root as possible.
- Trimming off the end of your hair **WILL NOT WORK**.
- In total, you will need to collect about 2 tablespoons of hair. It is advisable to cut hair from a few locations, rather than obtaining it all from one spot. This helps to avoid any noticeable changes to your hair style.
- Once your hair has been collected, please place it as close to the bottom of a Ziplock bag as possible.

Saliva Collection:

- Using two clean Q-Tips, wet each end of both Q-Tips with the saliva in your mouth. This can be done by rubbing it against your cheeks, gums, and/or tongue.
- Place the Q-Tips containing your saliva in the same, clean Ziplock bag used to collect your hair sample

Shipping Information:

- Our office is closed Friday through Sunday of every week. Ideally, it would be best that your sample is mailed on Monday. This reduces the chance of it sitting in the post office or mailbox.
- Please include your new patient paperwork with your sample.
- Our mailing address is:
  Platinum Wellness Center
  1019 North 1st Street
  Pulaski, TN 38478