Platinum Wellness Center, LLC
"Opening the Door to the Future of Healthcare"
Jamey Hagan MSN, FNP-C, CEO
M. Hope Hagan, FNP-C

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 also 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 finically responsible for my monthly membership fees or any 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, FNP-C, CEO or M. Hope Hagan, FNP-C and whomever he may suitably 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 ever had, any of the following conditions?

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

Are you allergic to 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 or 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 operation. This request must be done 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:

_____ _____

Print 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 Card 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 cost of 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 child per month. 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 ultimate health status. Any child typically between the ages of 7 to 17 years of age may join with one active parent membership.

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

Please provide the Credit Card information to use for membership: C.C. Name:_____
C.C. #:_____ Ex. Date:_____ CVC #:_____
(This information will never be shared and will always remain private)

_____ _____
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. CANNOT have 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 1 tablespoon of hair. It is advisable to cut hair from a few locations, rather than obtaining it all in 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 the 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, 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 avoids 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