Primary Care Physicians, PC
Excellent Support, Administrative Efficiency & Value

The Patient-Centered Medical Home

A Patient-Centered Medical Home promotes a close partnership between you and your personal physician.
Patients who choose to receive care in this way have the benefit of a medical home overseen by a Primary Care Physician of their choice, to help them through today's complex medical system.

Your personal physician:

- Is trained to provide first contact and constant and complete care for you.
- Leads a team of health care providers who will handle your ongoing care.
- Will provide or arrange all your health care with other health care professionals, community service agencies and, when appropriate, your family.
- Will work closely with other physicians, you and your family to set-up health care goals and treatment options to achieve. You will have improved access to care with open scheduling, expanded office hours and many communication options.

You will be expected to:

- Actively participate in decision-making and feedback to ensure your expectations are being met.
- Participate in the health care provider's quality improvement activities.

The Patient-Centered Medical Home includes care for all stages of your life and to ultimately make your life healthier.

Discussed with the patient: ***Arthur I. Bouier, D.O. / Michelle B. Calhoun, D.O***

Patient Acknowledgement initials: _____

Date: _____

Talk with your doctor about any additional questions

Platinum Care Physicians, PC
Body Image – Medical Weight Loss
27207 Lahser, Ste 250
Southfield, Michigan 48034
Office: (248) 967-3200
Fax: (248) 967-1387
Email: platinum_care@aol.com
Website: platinumcarephysicianspc.com

I, _____ authorize **Arthur I. Bouier/Michelle Calhoun, D.O.,** or whomever they may designate as their assistants to provide medical treatment for Preventive Care Services or Weight Loss/Weight Maintenance.

Signature on File:

Patient Name: _____**Date of Birth:** _____**Last 4 Digits SS#**_____

I request that payment of my insurance benefits be made on my behalf, spouse or dependent to: **Arthur Bouier, D.O**. and/or **Michelle Calhoun, D.O**. for all services provided.

I authorize the release of my medical information, which is necessary to process my claims, eligibility of benefits, coverage of services and procedures to the Health Care Financing Administration (HCFA) and its agents and/or to other insurance companies with which I have coverage with. **I acknowledge that it is my responsibility to provide complete and accurate information about all insurance(s) that I am insured with. I furthermore acknowledge that I am responsible for all deductibles, co-payments or any amount (s) that are not covered by my insurance.**

Consent for Medical Treatment:

I give my consent for my entire course of medical treatment for my past, present or future medical conditions. I further acknowledge that no guarantees of services have been given to me concerning the results intended from the treatment I will receive. By signing below, I acknowledge that I have given written consent to **Arthur Bouier, D.O.** and/or **Michelle Calhoun, D.O.** for evaluation and treatment.

Consent for Weight Loss/Weight Maintenance:

Weight Loss and is not covered by most health insurances, unless you are considered to be **Morbidly Obese or have a Medical Condition that is caused by Obesity.** Due to Dr. Arthur Bouier and/or Dr. Michelle Calhoun being a healthcare provider for several HMO insurances, weight loss is not a covered benefit or classified as a medical necessity by your health plan. **Your health insurance is designed for medical benefits that cover Well Visits, Preventive Services, Laboratory services, Hospitalization and Diagnostic Services**

I understand that medication prescribed for the weight loss program is classified as a Controlled Substance/Appetite Suppressant and can only be dispensed or prescribed once every thirty days. I also understand that if my medication is lost/stolen it will not be replaced and I will have to wait thirty days to be seen in the office and a new prescription be issued.

Date: _____ **Signature of Insured/Guardian:**_____.

Witness: _____ **Time:** _____

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

New Patient Medical History

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____

How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
☐ Hypertension		Other(s):	
☐ High Cholesterol			
☐ Hypothyroidism (low thyroid)			
☐ COPD, Emphysema or Asthma			
☐ Diabetes			
☐ GERD			
☐ Depression or Anxiety			
☐ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: Tylenol	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

☐ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Dr. Bower / Dr. Calhoun in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

Platinum Care Physicians Payment Policy

Co-Pays and Deductibles: We require payment of co-pays and deductibles at the time of service, and reserve the right to refuse treatment. This is part of your contract with your insurance company.

No Insurance: If you have no insurance, we collect $250 for your initial office visit and $125 for your follow-up visits.

Payments: We accept cash, Visa, MasterCard, Discover and Care Credit. Platinum Care Physicians will send patients accounts to collections for balances not paid after receipt of two statements unless you make payment arrangements with our office. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding balances: We may refuse to see patients with balances over $250, and who are not making regular payments on the balance. If you have an unpaid balance at the end of a billing cycle, we apply a $5 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an NSF check, there will be a $30 NSF charge added to the balance due.

Cancellations: We charge a $25 fee if you do not call and cancel your appointment 24 hours in advance. Notification allows the doctor to see another patient who needs to be cared for that day.

Claim Filing: We happily file your claim with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not
covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to Platinum Care Physicians, and we will apply it to your account.

Workers Compensation/Accident Claims: If your claim is denied you will be responsible for payment in full.

Forms/Medical Records: We may bill $75 for forms or letters that a provider completes on your behalf. We charge $50 copy fee for medical records requested for personal use.

Attestation Statement:

I have read, understand, and agree to the above Platinum Care Physicians, PC Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Platinum Care Physicians, PC to extend credit.

I authorize my insurance benefits to be paid directly to Platinum Care Physicians, PC.

I authorize Platinum Care Physicians, PC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____

Print Name of Patient Date

_____

Signature of patient or Responsible party

Platinum Care Physicians, PC
Body Image Weight Loss

Pregnancy Acknowledgement/Release

There are unknown risks to an unborn child when taking prescribed medications: Adipex 37.5 mg (Phentermine), Zoloft 25/50 mg or Wellbutrin 75/150 XL mg.

It is the policy of Platinum Care Physicians PC/Body Image Weight Loss that if there is a possibility you are or suspect you may be pregnant, it is strongly recommended that you discontinue taking all medications prescribed for the weight loss program, until it can be confirmed that you are not pregnant.

I _____ understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Dr. Bouier and Dr. Calhoun if I am pregnant, if I am trying to become pregnant, or if I become pregnant during the course of these treatments.

If I do not follow these recommendations, I agree to release the doctor and facility from any liability arising as a result of this.

I have read and understand the above information provided:

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

Date: _____

Witness: _____

Urine Screen

Arthur I. Bouier, D.O./Michelle B. Calhoun, has requested that a sample of your urine be tested to monitor the levels of medication in your system. The purpose of this urine drug screen is to:

- Prevent dangerous drug to drug interactions.
- Monitor medication compliance with your treatment plan.
- Reduce the risk of adverse side effects from the medications I have prescribed you or medications you were previously prescribed by another physician.
- Identify the most appropriate treatment plan for your individual medical needs.

Please understand the following:

- **Platinum Care Physicians, P.C.** will maintain confidentiality of your test results.
- Test results will not be released without your advance written consent or as otherwise permitted by law.
- Unless we are required by law, or under circumstances that fall under HIPAA guidelines test results will be given to other medical professionals.

Platinum Care Physicians, P.C., will bill your health insurance for this screening test, and accept fees that are determined by your insurance carrier.

INFINITI LABS

www.Infiniti-Labs.com

Infiniti Labs Medication Monitoring Authorization

By signing this document I, (print name), _____

Authorize Infiniti Labs, Inc to run a complete Medication Monitoring profile for a period of 12 months. Additionally, I authorize Infiniti Labs, Inc to bill my insurance company, and that in some circumstances my insurance company will send proceeds directly to me. Under law, I agree to endorse the insurance check and forward it to Infiniti Labs within 30 days.

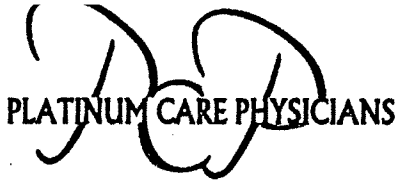
The results of the medication monitoring test will be reviewed by the medical staff and may be used to assist with medical/psychiatric treatment.

An Infiniti Labs, Inc Medication Monitoring Requisition must be completed and sent with each sample.

_____ _____

Signature Date

6015 Benjamin Road, Suite 315 Tampa, FL 33634
Telephone: 813-886-2616 Fax: 813-886-2735
www.Infiniti-Labs.com



ARTHUR I. BOUIER, D.O., F.A.C.O.I · MICHELLE B. CALHOUN, D.O.
PRIMARY CARE · INTERNAL MEDICINE · MEDICAL BARIATRICS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security # _____

I authorize **PLATINUM CARE PHYSICIANS** to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, zip code

_____
Phone#/Fax# (include area code)

Type of records requested

- o Immunization history
- o Treatment summary (includes: history & physical, laboratory tests & x-ray reports, operative reports, pathology)
- o Specific information: (circle all that apply)

  Procedure Report — History & Physical — Physical Therapy
  Laboratory test results — X-ray reports
- o Copy of the entire medical record, as allowed by law.

AUTHORIZATION VALID FOR ONE YEAR FROM DATE OF THIS AUTHORIZATION.

_____ _____
Signature of Patient or Representative — Relationship to Patient

_____
Date

27207 LAHSER ROAD · SUITE 250 · SOUTHFIELD, MICHIGAN 48034 · 248.967.3200 · FAX: 248.967.1387

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

PATIENT:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

Notice to all Patients:

By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of treatment, various activities associated with payment and health care operation. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying the consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Pricacy Officier.

You have the right to revoke your consent by giving written notice to our Privacy Officier. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke the Consent we may decline to treat you. You are entitled to a copy of this Consent Form after you have signed it.

To be completed by Patient or Patient's Representative:

I,_____, have read the contents of this Consent Form and the Notice of Privacy Practices, I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____

Printed Name of Patient/or Representative Date

_____ _____

Signature of Patient/or Representative Relationship to Patient

Our Privacy Officier, Mrs Aquarius Caughman can be contacted at the number listed on the first page..