NEW PATIENT INTAKE FORM

Welcome to Michigan Healthcare Institute / Michigan Weight Loss Institute.

Please complete the following information so we can provide you with the highest quality medical care.

PATIENT INFORMATION					
Patient Name				Date	
Date of Birth			SSN		
Sex assigned at birth	□ Male □ Female □ Other:				
Address				City	
State		Zip		Primary Phone	
Email Address				Occupation	
Employer				Phone #	
Primary Care Physician (PCP)				Phone #	

INSURANCE INFORMATION					
Primary Insurance Company					
Subscriber Name			DOB		
Relationship to Patient	□ Self □ Spouse □ Parent □ Other				
Insurance ID Number		Group Number			
Secondary Insurance		Secondary ID			
How did you hear about us?	□ Physician Referral □ Friend / Family □ Google / Internet □ Social Media. □ Other _____				

EMERGENCY CONTACT			
Name		Phone #	
Relationship			
Share Medical Information?	□ Yes □ No		

PHARMACY INFORMATION					
Pharmacy Name				Phone	
Pharmacy Address				City	
State		Zip			

Current Medications

Please list all medications you currently take, including prescription, over-the-counter, and dietary supplements. You may also provide your own printed list.

Medication	Dose/Frequency	Reason

ADVANCED BODY COMPOSITION ASSESSMENT (BCA Scale) – $30

This service is not billed to insurance.

At Michigan Weight Loss Institute, we use a Body Composition Analysis (BCA) Scale Assessment to help track your progress throughout your weight loss journey.

This assessment measures:

- Weight
- Skeletal Muscle Mass
- Percent Body Fat

Tracking these measurements over time helps our team personalize your treatment plan, monitor your progress, and support you in achieving your goals.

If you have previously completed a body composition analysis at another facility or gym, please notify our team.

By signing below, I acknowledge that **the Body Composition Analysis (BCA) Scale Assessment is a $30 cash-pay service not billed to insurance** and will be used to help monitor my treatment progress.

Patient Signature: _____Date:__ _____

BEHAVIORAL MODIFICATION PROGRAM

I acknowledge that, as part of my comprehensive treatment plan, I may be prescribed a behavioral modification program to promote long-term success. I agree to actively participate in the program as directed by my physician.

Initial_____

PATIENT RESPONSIBILITY TO UPDATE INFORMATION

It is the patient's responsibility to notify Michigan Healthcare Institute PLLC of any changes to personal information including but not limited to: phone number, address, insurance plan, emergency contact, and legal name. Failure to provide updated information may result in delays in care, billing errors, or claim denials.

I understand and agree to update my information as needed. **Initial_____**

CANCELLATION & NO-SHOW POLICY

To respect the time of our providers and other patients, we request that you notify Michigan Healthcare Institute PLLC / Michigan Weight Loss Institute at least 24 hours in advance if you need to cancel or reschedule your appointment.

Appointments canceled with less than 24 hours' notice or missed appointments may be subject to a $50 cancellation or no-show fee.

Repeated missed appointments may result in dismissal from the practice.

I acknowledge the **$50 no-show / same-day cancellation fee.**

Signature: _____ Date: _____

SPECIALIST COPAY NOTICE

Michigan Healthcare Institute PLLC / Michigan Weight Loss Institute is classified as a **specialist office** by most insurance carriers. As a result, your insurance plan may apply a specialist copay, which is typically higher than a primary care copay, to each visit.

Your specific copay amount is determined by your insurance plan, not by our office. Copays are due at the time of service. We recommend confirming your specialist copay with your insurance carrier prior to your appointment.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize payment of medical benefits directly to Michigan Healthcare Institute PLLC for any services provided to me. I authorize Michigan Healthcare Institute PLLC to release medical or other information necessary to process insurance claims.

I understand that my health insurance policy is a contract between my insurance carrier and me. I am ultimately responsible for payment of all charges for services rendered, including but not limited to: deductibles, copayments, coinsurance, non-covered services, and services denied by insurance.

Copayments and known patient responsibility amounts are due at the time of service. If my insurance does not pay or denies payment for any reason, I agree to be financially responsible for the remaining balance. Balances not paid within 30 days of the statement date may be subject to collection.

By signing below, I acknowledge that I have read, understand, and agree to all policies and authorizations listed above, including the Financial Responsibility, Specialist Copay Notice, and Assignment of Insurance Benefits.

Patient Name (print): _____

Signature: _____ Date: _____

41400 Dequindre Road, Suite 105, Sterling Heights, MI 48314
P: 586-287-7330 F: 586-287-7337

32000 Telegraph Rd., Bingham Farms, MI 48025
P: 248-573-3110 F: 586-287-7337

AUTHORIZATION FOR TREATMENT & CONSENT TO CARE

1. AUTHORIZATION FOR MEDICAL TREATMENT

I authorize the providers and staff of Michigan Healthcare Institute PLLC to perform medical evaluation and provide treatment as deemed medically necessary by my treating provider. This care may include, but is not limited to:

- ☑ Physical examinations and diagnostic testing
- ☑ Laboratory services and specimen collection
- ☑ Administration of medications, biologics, and/or injections
- ☑ Medical and nursing care, including chronic disease management
- ☑ Preventive care, health screenings, and wellness services

2. TEACHING INSTITUTION DISCLOSURE

Michigan Healthcare Institute PLLC is a teaching institution. Medical students, residents, and/or trainees may participate in your care under the direct supervision of a licensed physician. You have the right to decline trainee involvement in your care at any time without affecting the quality of your care. Requests to opt out must be made in writing at the front desk.

□ I consent to trainee involvement in my care. □ I decline trainee involvement in my care.
Patient Initials: _____

3. CONSENT TO TELEHEALTH SERVICES

I consent to receive care from Michigan Healthcare Institute PLLC via telehealth (secure audio and/or video) when approved by my physician or PA. Telehealth visits follow the same standard of care and HIPAA protections as in-person visits but carry inherent risks, including technology failures, limited physical examination, and possible unauthorized access despite reasonable safeguards. Some conditions require in-person care, and certain medications cannot be prescribed via telehealth under state and federal law. Telehealth is not for emergencies—in an emergency, I will call 911 or go to the nearest ER. I may withdraw consent or request an in-person visit at any time without affecting my care.

□ I consent to telehealth services □ I decline telehealth services
Patient Initials: _____

By signing below, I confirm that I have read and understood all sections of this Authorization for Treatment and Consent to Care. I have had the opportunity to ask questions, and I agree to the terms stated above.

Patient Name (print): _____

_____ _____
Patient Signature Date

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HIPAA PATIENT ACKNOWLEDGEMENT & CONSENT

Michigan Healthcare Institute PLLC ("MHI") is required by law to maintain the privacy and security of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice is effective February 16, 2026.

To comply with HIPAA requirements, Michigan Healthcare Institute PLLC is providing you with a copy of our Notice of Privacy Practices ("NPP"). The NPP describes how we may use and disclose your health information for treatment, payment, and health care operations, as well as for other purposes permitted or required by law. You have the right to review the NPP before signing this acknowledgement.

Please note that Michigan Healthcare Institute PLLC may create, receive, or maintain records related to substance use disorder (SUD) diagnosis, treatment, or referral for treatment. If applicable, such records are subject to additional federal confidentiality protections under 42 C.F.R. Part 2, which in certain respects are more restrictive than HIPAA. Your SUD records may only be used or disclosed with your written consent or as otherwise permitted under 42 CFR Part 2. Your acknowledgement below includes receipt of the SUD-specific privacy provisions described in Section 3 of our Notice of Privacy Practices.

Without your written authorization, we may use or disclose your health information only as described in our Notice of Privacy Practices, including but not limited to:

•Treatment, payment, and health care operations
•As required by law, including public health and health oversight activities
•Judicial and administrative proceedings under specific legal requirements
•Serious threats to health or safety
•Workers' compensation and other legally authorized programs

In the course of your treatment, it may be necessary for us to share your health information with other covered entities involved in your care, including specialist providers, laboratories, or other healthcare professionals coordinating your treatment.

You may revoke any written authorization you have provided to us at any time, in writing, except to the extent that we have already relied upon it. To revoke an authorization or to exercise any of your privacy rights, please contact our Privacy Officer: Raven Haddad, R.N., B.S.N. at 586-287-7330 or rhaddad@mihealthcareins.com.

Patient Acknowledgement

I acknowledge that I have received and agree to the Notice of Privacy Practices.

_____

Patient or Parent/Guardian Signature

_____

Patient Name (please print)

_____

Date

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Rita Kathawa, M.D., M.A.
Stephanie Shaheen, PA-C

MORPHEUS8 RF MICRONEEDLING CONSENT FORM

Patient Name: _____ Date: _____

Treatment Area(s): _____

Description of Procedure

Morpheus8 is a minimally invasive cosmetic treatment that combines microneedling with radiofrequency (RF) energy to stimulate collagen production and improve skin texture, tone, and tightness. Tiny microneedles deliver RF energy into the deeper layers of the skin, promoting collagen remodeling and tightening. Multiple sessions are typically recommended for optimal results.

Potential Benefits

- Skin tightening
- Reduction in wrinkles and fine lines
- Improved skin texture and tone
- Reduction in acne or surgical scars
- Improvement in skin laxity
- Results vary and are not guaranteed.

Possible Side Effects and Risks

- Redness
- Swelling
- Bruising
- Temporary numbness or sensitivity
- Infection (rare)
- Hyperpigmentation or hypopigmentation

Contraindications

Morpheus8 may not be appropriate if I have certain medical conditions, including but not limited to:

- Active skin infection
- Open wounds in the treatment area
- Pregnancy
- Implanted electronic devices (pacemaker, defibrillator)
- Certain skin conditions or recent treatments
- I have disclosed all relevant medical history to my provider.

Post-Treatment Expectations

Following treatment, I may experience redness, swelling, mild sensitivity, dryness, or temporary pinpoint scabbing for several days. I agree to follow all post-procedure care instructions to minimize the risk of complications. I understand that cosmetic procedures are not an exact science, no specific results are guaranteed, and multiple treatments may be needed to achieve desired outcomes.

Photography Consent

I authorize Michigan Healthcare Institute PLLC to take photographs of the treatment area for medical documentation, treatment planning, and monitoring results. ☐ Yes ☐ No

Financial Responsibility

I understand that Morpheus8 is a cosmetic procedure not covered by insurance, and that payment is required in accordance with the practice's financial policy.

Patient Acknowledgement

I certify that I have read and understand this consent form, that all my questions have been answered to my satisfaction, and that I voluntarily consent to the Morpheus8 treatment.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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PHOTOGRAPHY & MEDIA RELEASE AUTHORIZATION

PATIENT INFORMATION

Patient Name: _____ DOB: _____Date: _____

PHOTOGRAPHY AUTHORIZATION

I understand that photographs, videos, or other images may be taken before, during, and after medical or cosmetic treatments performed at **Michigan Healthcare Institute PLLC / Michigan Weight Loss Institute.** These images may be used for:

•Medical documentation

•Treatment planning and monitoring

•Medical education and training

•Marketing and promotional purposes, including website, social media, advertising, and before-and-after displays

I understand that my name or identifying information will not be used; however, complete anonymity cannot be guaranteed.

VOLUNTARY CONSENT

Participation in photography is voluntary and will not affect my medical care. I understand that I will not receive compensation and that previously published images may not be withdrawn if consent is later revoked.

PATIENT CONSENT

Please select one:

□ I authorize photography for medical records only, including medical documentation & educational purposes.

□ I authorize photography for medical documentation and marketing purposes, including website, social media, and promotional materials.

I certify that I have read and understand this Photography & Media Release Authorization and voluntarily consent to the use of my images as indicated above.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Witness / Staff Name: _____

Witness / Staff Signature: _____ Date: _____

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