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

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	
Gender	□ Male □ Female	Marital Status	□ Single □ Marred □ Divorced □ Widowed	

CONTACT INFORMATION					
Address				City	
State		Zip		Primary Phone	
Email Address					
How did you hear about us?	□ Physician Referral □ Friend / Family □ Google / Internet □ Social Media □ Other ______________________				

EMPLOYMENT / PRIMARY CARE			
Employer		Phone #	
Primary Care Physician (PCP)			
Physician 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	

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

PHARMACY INFORMATION			
Pharmacy Name		Phone	
Pharmacy Address		City	
State		Zip	

COMMUNICATION PREFERENCES			
Phone Call	☐	Voicemail	☐
Text Message	☐	Email	☐
Preferred Contact Method			

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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 cancelled with less than 24 hours' notice or missed appointments may be subject to a $20 cancellation or no-show fee.
Repeated missed appointments may result in dismissal from the practice.

AUTHORIZATION FOR TREATMENT

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

- Physical examinations
- Diagnostic testing
- Laboratory services
- Administration of medications or biologics
- Medical and nursing care

I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the results of treatment.

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 • 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.

By signing below, I acknowledge that I have read, understand, and agree to all policies and authorizations listed above, including the Cancellation & No-Show Policy, Authorization for Treatment, and Financial Responsibility / Assignment of Insurance Benefits.

Patient Name (print): ____

Signature: ____ Date: ________________

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Patient Acknowledgement and Consent Form

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and may collect in the future.

To comply with one of the HIPAA requirements, Michigan Healthcare Institute PLLC is providing you with a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan laws require (in addition to our attempt to obtain your written acknowledgement, discussed above) that we first obtain your written consent prior to disclosing any of your information except for disclosures made in connection with: a defense claim challenging our professional competence; a review entity's function; a claim for payment of fees; a third-party payer's examination of our records; a court order as part of a criminal investigation; identification of a deceased individual; a licensure investigation; or a child abuse or neglect investigation.

In some instances, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another covered entity for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

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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Weight Loss Medical History Questionnaire

Please answer the following questions to help us understand your health history and weight management goals.

Current Height: ____________________

Current Weight: ____________________

Goal Weight: ______________________

When did you first begin struggling with weight gain?

____

____

Have you previously tried to lose weight?

□ Yes

□ No

If yes, which methods have you tried?

□ Diet programs (Weight Watchers, etc.)

□ Exercise programs

□ Prescription medications

□ GLP-1 medications

□ Meal replacement programs

□ Bariatric surgery

□ Other ______________________

What worked best for you?

____

____

What challenges have made weight loss difficult?

□ Hunger / cravings

□ Emotional eating

□ Busy schedule

□ Medical conditions

□ Medications

□ Lack of exercise

□ Other ______________________

Lifestyle & Nutrition Assessment

How many meals do you typically eat per day?

□ 1 □ 3

□ 2 □ 4+

How often do you exercise?

□ Rarely

□ 1-2 times per week

□ 3-4 times per week

□ 5+ times per week

Types of exercise you participate in:

□ Walking

□ Running

□ Strength training

□ Group fitness

□ Yoga / Pilates

□ Other ______________________

How many hours of sleep do you get per night?

□ Less than 5 □ 7-8

□ 5-6 □ 9+

Medical History

Do you currently have or have you ever been diagnosed with:

□ Diabetes

□ Prediabetes

□ High blood pressure

□ High cholesterol

□ Thyroid disorder

□ PCOS

□ Sleep apnea

□ Heart disease

□ Depression / anxiety

□ Other ________________

____

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

Current Medications

Please list all medications you currently take (or you may provide your own list):

Medication	Dose	Reason

Weight Loss Treatment Expectations Agreement

At Michigan Healthcare Institute PLLC / Michigan Weight Loss Institute, our goal is to support patients in achieving safe, sustainable weight loss through medical care, lifestyle guidance, and evidence-based treatment.

By participating in this program, I understand and agree that:

- Weight loss results vary from patient to patient.
- No guarantees can be made regarding the amount or rate of weight loss.
- Long-term success requires lifestyle changes, including nutrition, physical activity, and behavioral changes.
- Prescription medications may be recommended as part of treatment when medically appropriate.
- Regular follow-up visits may be required to monitor progress and ensure safety.

I agree to actively participate in my treatment plan and to communicate honestly with my provider regarding my health history, medications, and lifestyle habits.

Body Composition / InBody Analysis Consent

Michigan Healthcare Institute may perform body composition analysis as part of the weight management program. This test measures body fat percentage, muscle mass, and metabolic indicators.
I understand that this information helps guide my personalized weight management plan.

Program Participation Acknowledgement

I understand that some services offered by Michigan Healthcare Institute PLLC / Michigan Weight Loss Institute may not be covered by insurance and may require payment at the time of service.

These services may include:

- Body composition analysis
- Nutritional counseling
- Weight management program visits
- Cosmetic or wellness services

I acknowledge that I have been informed of these policies and agree to comply with the financial policies of the practice.

By signing below, I acknowledge that I have read, understand, and agree to the Weight Loss Treatment Expectations Agreement, Body Composition / InBody Analysis Consent, and Program Participation Acknowledgement outlined above.

Patient Name:

____

Signature: ____Date: ______________________

Rita Kathawa, M.D., M.A.
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GLP-1 / Weight Loss Medication Safety Agreement

Weight loss medications such as GLP-1 receptor agonists (including semaglutide or tirzepatide) may be prescribed as part of a medically supervised weight management program when appropriate.

I understand that:

• These medications are prescription medications and must be taken exactly as directed.
• Potential side effects may include nausea, vomiting, constipation, diarrhea, or other gastrointestinal symptoms.
• Rare but serious risks may include pancreatitis, gallbladder disease, or allergic reactions.
• I should contact the clinic immediately if I experience severe or concerning side effects.
• These medications may not be appropriate for all patients, including those with certain medical conditions or family histories.

I understand that medication coverage by insurance is not guaranteed and that I may be responsible for medication costs if insurance does not cover them.

I agree to follow the medical guidance provided by Michigan Healthcare Institute PLLC and to attend recommended follow-up appointments.

Patient Name: ____

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.

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 I will not receive compensation and that previously published images may not be able to be withdrawn if consent is later revoked.

PATIENT CONSENT
(Please select one)

□ I authorize photography for medical records only.

□ I authorize photography for medical documentation and educational purposes.

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

PATIENT ACKNOWLEDGEMENT

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: ___________