Patient Information

Reason for Treatment: _____

Referring Provider: _____ **Date:** _____

How Did You Hear About Us? ☐ Provider ☐ Friend ☐ Other: _____

PATIENT INFORMATION

Patient Name: First: _____ **MI:** _____ **Last:** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

DOB: _____ **Social Security #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____

Home #: _____ **Mobile:** _____

Driver's License #: _____ **Height:** _____ **Weight:** _____

Occupation: _____ **Work #:** _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ Asian ☐ African American ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State

Emergency Contact: _____ **Relationship:** _____

Phone: _____ **Email:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Holder Name: _____ **Holder DOB:** _____

Holder's Relationship to Patient: _____ **Plan Type:** ☐ HMO ☐ PPO ☐ POS ☐ Medicare

(if HMO or POS) **IPA/Group Name:** _____ *(if HMO or POS)* **IPA/Group Phone # for Authorizations:** _____

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Holder Name: _____ **Holder DOB:** _____

Holder's Relationship to Patient: _____ **Plan Type:** ☐ HMO ☐ PPO ☐ POS ☐ Medicare

(if HMO or POS) **IPA/Group Name:** _____ *(if HMO or POS)* **IPA/Group Phone # for Authorizations:** _____

To our patients: We ask all patients to show their insurance cards and photo ID

Signature of Patient or Authorized Rep: _____ **Date:** _____

Your Health Profile

INFUSION FOR HEALTH

Patient Name: _____

PLEASE LIST ANY ALLERGIES AND REACTIONS:

HEALTH HISTORY:

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Pacemaker or Defibrillator
- ☐ Heart Disease
- ☐ A-Fib
- ☐ Other: _____

Endocrine

- ☐ Diabetes
  - ☐ Type I ☐ Type II
- ☐ Thyroid Disease
  - ☐ Hyper ☐ Hypo
- ☐ Grave's Disease
- ☐ Other: _____

Neurology

- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Seizures
- ☐ Migraines
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Other: _____

Allergy & Immunology

- ☐ Allergic Rhinitis
- ☐ C I D P
- ☐ Primary Immunodeficiency
- ☐ Systemic Lupus Erythematosus
- ☐ Other: _____

Respiratory

- ☐ C O P D
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Other: _____

Skin Conditions

- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives/Urticaria
- ☐ Other: _____

Musculoskeletal

- ☐ Osteoporosis
- ☐ Loss of sensation, tingling, numbness
- ☐ Other: _____

Blood/Immune/Cells

- ☐ Iron deficiency anemia
- ☐ Hemophilia
- ☐ Easy brusing
- ☐ HIV/AIDS
- ☐ Other: _____

Rheumatology

- ☐ Gout
- ☐ Rheumatoid Arthritis
- ☐ Plaque Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Other: _____

Women

- ☐ Currently pregnant
- ☐ Hyperemesis
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Other: _____

G I

- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ GERD/reflux
- ☐ Other: _____

GU/Chronic Kidney Disease

- ☐ Stage 1 ☐ Stage 2
- ☐ Stage 3 ☐ Stage 4
- ☐ Dialysis

Psychological

- ☐ Anxiety
- ☐ Depressions
- ☐ Other: _____

Cancer

- ☐ Breast
- ☐ Prostate
- ☐ Other: _____

Your Health Profile Continued...

INFUSION FOR HEALTH

Patient Name: _____

MEDICATIONS / SUPPLEMENTS / VITAMINS

Name:	Dose:	Frequency:

☐ See Attached

INJURIES / ACCIDENTS / SURGERIES

Year:	Description:

SMOKING / DRINKING

Smoker? ☐ No ☐ Yes **Former Smoker?** ☐ No ☐ Yes **Pks/day:** _____ **Age Quit:** _____

☐ Cigarettes ☐ Cigar ☐ Vape ☐ Second Hand Exposure

Drink Alcohol? ☐ No ☐ Yes **Type:** ☐ Wine ☐ Beer ☐ Other **Drinks per week:** _____

Recreational Drugs? ☐ No ☐ Yes **Type:** _____ **Frequency:** _____

Quit? ☐ No ☐ Yes **Age Quit:** _____

Caffeine? ☐ Coffee ☐ Tea ☐ Energy Drinks **How many a day?** _____

Your Health Profile Continued...

Patient Name: _____

FAMILY HISTORY

Mother: Medical History: ☐ Alive ☐ Deceased Age: _____

Cause:

Father: Medical History: ☐ Alive ☐ Deceased Age: _____

Cause:

IFH PC Financial Policy

We would like to thank you for choosing Infusion for Health as your healthcare provider. Infusion for Health is committed to providing you with the best possible medical care. The following information outlines your financial responsibilities related to payment for professional services. By signing this document, you agree to the terms and conditions outlined in our financial policy.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many PPO's, insurance companies and government agencies including Medicare. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please bring your insurance card with you at the time of your appointment.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

If there is a change in your insurance, it is your responsibility to inform us of this change immediately. Lack of communication in change of insurance will be your responsibility and require a payment in full before the next treatment is rendered.

Deductible / Co-Insurance:

We require the collection of your applicable deductible or co-insurance, as required by your insurance at the time of service. For your convenience, we accept cash, checks or the following credit cards: Visa, MasterCard, Discover and American Express. If you do not have your agreed upon payment, your appointment may be rescheduled. This amount will be estimated before your appointment and will be collected at the time of service. Any outstanding balance on your account, after adjusting for all your insurance's responsibilities, will be billed to you**. Enrollment in a medication co-pay assistance program is the only exception to this policy.**

Waiver of Patient Responsibility:

It is the policy of Infusion for Health to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount coinsurance, deductibles, or other patient financial responsibilities in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Charity/Free Care Policy.

Non-Covered and Out of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Coverage Changes:

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive the maximum benefits.

For Our Patients with No Medical Insurance:

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

- **PAYMENT PLAN OPTIONS:** Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship - call (800) 369-9165 for assistance.

Late Arrivals:

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of Infusion for Health, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

Appointment No-Shows:

Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". **Please allow 24 hrs. to change or cancel your appointment to avoid a cancellation fee of $50.00 for injections or $100.00 for infusions**. A patient who fails to present themselves two times for scheduled appointments is considered a chronic no-show. A patient who is a no- show three times may be dismissed by Infusion for Health.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance **in excess of 120 days** if the patient has not made any payment or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Non-Payment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will only be able to treat you on an emergency basis.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Signature: _____ **Date:** _____

Insurance Responsibilities

If you have....	You are Responsible	Our Staff Will
Commercial Insurance Also known as indemnity, "regular" insurance, certain % split between patients and insurance companies.	For payment of the patient responsibility for all infusion, injection, and or any other charges. **This is requested at the time of the office visit.**	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
PPO plans with which we have a contract.	If the services you receive are covered by the plan: **All applicable deductibles and co-insurance are requested at the time of the office visit.** If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine deductibles, co-insurances, and non-covered services for you. File an insurance claim on your behalf.
Point of Service Plan or Out of Network PPO	For payment of the patient responsibility- deductible, co-insurance, non-covered services. **This is requested at the time of the visit.**	Call your insurance company ahead of time to determine out of network benefits, deductibles, co-insurance, and non-covered services. File an insurance claim on your behalf.
Medicare PPO We are not contracted with Medicare HMO	If you have Regular Medicare, and have not met your deductible, **this is requested at the time of the office visit.** Any services not covered by Medicare payment is **requested at the time of the visit.** If you have Medicare as primary, and also have a secondary insurance**: No payment is necessary at the time of the visit.** If you have Medicare as primary, but no secondary insurance: **Payment of your 20% co-pay is requested at the time of the visit.**	File the claim on your behalf, as well as any claims to your secondary insurance.
No Insurance	**Payment in full at the time of the visit.**	Work with you to settle your account. Please ask to speak with the Billing Office staff if you need assistance.

Signature: _____ **Date:** _____

HIPAA Privacy Practice

HIPAA privacy rules give individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

My signature below constitutes my acknowledgment that I have been advised of the HIPPA privacy rule.

Signature: _____ **Date:** _____

Printed Name: _____

If not signed by Patient, please indicate relationship: _____

Please advise us with whom we may share your information directly.

Your medical records and health information are confidential and protected under HIPPA. We take the responsibility to secure your medical information seriously. No information will be given to any person unless they have your expressed authorization below: **PLEASE CHECK AND INDICATE NAME(S):**

Durable Power of Attorney: ☐ No ☐ Yes Who: _____

Advance Directive: ☐ No ☐ Yes

MARK	RELATIONSHIP	NAME & PHONE #
☐ Yes	Spouse	
☐ Yes	Parent	
☐ Yes	Guardian	
☐ Yes	Child	
☐ Yes	Partner	
☐ Yes	Other:	

I wish to be contacted in the following manner (check all that apply):

MARK	LEAVE MESSAGE?	METHOD	PLEASE ENTER PHONE, FAX, OR EMAIL
☐ Yes	☐ Yes ☐ No	Home Phone	
☐ Yes	☐ Yes ☐ No	Work Phone	
☐ Yes	☐ Yes ☐ No	Cell Phone	
☐ Yes	☐ Yes ☐ No	Fax	
☐ Yes	☐ Yes ☐ No	Email	
☐ Yes	☐ Yes ☐ No	Other	

Consent to Treatment

Patient Name: _____

I hereby request services of Infusion for Health, and I consent to such treatment. medications, and procedures as are ordered by my Provider and my Physician's associates to be provided by Infusion for Health. I agree that Infusion for Health is not liable for any act or omission when following a Provider's instructions. I also understand that if I need to be hospitalization or need special services during the course of my care, which are not provided by Infusion for Health, the services and hospitalization must be arranged by me, my legal guardian/representative or my Provider, are my responsibility.

- I will comply with all medically necessary procedures and treatments performed at the center.
- If my account balance becomes overdue and is placed with a collection or legal agency, I agree to pay all attorney or collection agency fees associated with my delinquent account.

I, the undersigned, give the authorization to Infusion for Health, to obtain any of my medical records, mailed or faxed, pertinent to my medical condition.

Authorization to Test and Release Information - You are hereby notified pursuant to California Law that as patient of this facility, you may be tested for the presence of HIV or an HIV antibody without your consent if any health care professional or other city employee sustains percutaneous, mucous membrane, or open wound exposure to your blood or other body fluids. This test is permitted by California Law, and is for your protection as well as the protection of the Physicians, Nurse Practitioners, nurses and other employees of the center.

I certify the information herein is correct to the best of my knowledge. I will not hold my Provider or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Print Name: _____ **Relationship:** _____

Signature of Patient or Authorized Representative: _____

Minor Name: _____

Date: _____