Patient Information

Reason for Treatment: ________________________________

Referring Physician: __________________________________

PATIENT

Name: First:_________________MI: _____ Last: _________________________

Sex: M ☐ F ☐ Prefer not to answer ☐ Other ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

DOB: _____/______/_____ Social Security #: ______________________________

Address: Street: ____________________ City: ___________ State:_______ Zip:_____

Email: ____

Home #: (_____) _____ -__________ Mobile: (_____) _____ -__________

Driver's License #: ____________________ Height: _________Weight: ____________

Occupation: _____________________________Work #: (_____) _____ -_____________

Emergency Contact Name: ______________________Relationship: _________________

Emergency Contact Phone #: ___________________ Email: _______________________

INSURANCE

Primary Insurance: ______________________________ Policy #: ___________________________

Policy Holder Name: ____________________________ Policy Holder DOB: _____/______/_____

Secondary Insurance: ___________________________ Policy #: ___________________________

Policy Holder Name: ____________________________ Holder DOB: _____/______/_____

We ask all patients to show their insurance cards and photo ID at time of service

INFUSION FOR HEALTH

Health Profile

Patient Name: ____

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Pacemaker or Defibrillator
- ☐ Heart Disease
- ☐ 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
- ☐ 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

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

Women
- ☐ Currently pregnant
- ☐ Hyperemesis
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Other: ____________

G I
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ GERD/reflux
- ☐ Other: ____________

Chronic Kidney Disease
- ☐ Stage 1
- ☐ Stage 2
- ☐ Stage 3
- ☐ Stage 4

Psychological
- ☐ Anxiety
- ☐ Depressions
- ☐ Other: ____________

Cancer
- ☐ Breast
- ☐ Prostate
- ☐ Other: ____________

INFUSION FOR HEALTH

Health Profile Continued

Patient Name: ____

MEDICATIONS / SUPPLEMENTS / VITAMINS

☐ See Attached List

Name:	Dose:	Frequency:

Smoker? No ☐ Yes ☐ **Former Smoker?** No ☐ Yes ☐ **Pks/day:** ______ **Year quit:** _________

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

Drink Caffeine? No ☐ Yes ☐ **Cups per week:** ______________

Health Profile Continued

Patient Name: ____

INJURIES / ACCIDENTS / SURGERIES

Year:	Description:

INFUSION FOR HEALTH

Health Profile Continued

Patient Name: ____

ALLERGIES

Allergen:	Description of Reaction:

Health Profile Continued

Patient Name: ____

PERTINENT FAMILY MEDICAL HISTORY

Family Member:	Description:

PATIENT ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ____

Thank you for choosing Infusion For Health. We are committed to providing you with the best possible care, including assisting our patients with understanding their financial responsibilities as it relates to the prescribed services. To ensure that you are familiar with our financial policies please read this document thoroughly and initial or sign where indicated.

Prior to your appointment, Infusion For Health staff will contact your insurance company to verify eligibility, coverage, and benefits. If active coverage is not available, Infusion For Health staff will contact you to review payment options for prescribed services. If prior authorization is required by your insurance plan, Infusion For Health staff will contact the insurance company to request authorization for services. To protect you from unexpected charges, services will not be rendered until we have verified active coverage and obtained any required prior authorization, or until we obtain a signed private payment agreement from you. Please remember to notify us prior to your next appointment of any insurance changes, such as when you change health plans, change employers, or your company offers a different health benefit plan.

Coverage, eligibility, and benefits are based on information provided by your insurance company. Checking coverage, eligibility, benefit information, and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined by your insurance company once a claim has been received. We encourage you to confirm this information directly with your insurance company. Your insurance carrier may need you to supply certain information directly. It is your responsibility to comply with their requests.

Infusion For Health is a participating provider with many commercial, Medicare, and Medicaid insurance carriers including managed care plans. We will bill the insurance carriers directly. You will be responsible for your share of cost as assigned by your insurance plan. These costs may include co-payments, coinsurance and/or deductible payments. Enrollment in a medication co-pay assistance program is the only exception to the share of cost policy. All health plan payments should be directed to Infusion For Health for direct payment. You should notify Infusion For Health immediately if health plan payments are made payable to you in error.

Our 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.

Telehealth Visits:

A telehealth visit will be scheduled for all new patients or patients receiving a new drug therapy. These visits are scheduled so the practitioner can review the plan of care, provide education, and prepare patients and their families for the first appointment in the clinic. These are essential for the success and safety of the patient. Telehealth visits will be billed to your insurance plan. Please contact your insurance carrier for information on any out-of-pocket costs associated with telemedicine.

Financial Responsibility (PLEASE READ AND INITIAL):

I acknowledge that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, coinsurance, and non-covered services, as dictated by my insurance coverage. I acknowledge that if any services provided by Infusion For Health are not covered by my insurance plan for one or more reasons, including but not limited to, exclusions from my insurance plan or funding limits with my insurance plan, out-of-network

provider, and/or failure to provide updated insurance information, I will be responsible for the full charge of all services. I acknowledge that cancelation fees are not billed to insurance carriers, and I agree to be financially responsible for those fees. Initial [_____]

To ensure you are not billed in error you must inform Infusion For Health of any active Medi-Cal or Medicaid coverage prior to services being rendered.

Assignment of Benefits (PLEASE READ AND INITIAL):

I hereby assign all benefits of my insurance and other funding sources to Infusion For Health for services rendered. I accept financial responsibility for all charges if I do not have medical insurance or if my medical insurance does not reimburse Infusion For Health for services provided. I understand that the services provided may not be covered by my insurance plan and that my insurance may assign to me a share of cost. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me. Initial [_____]

Cancellation Policy (PLEASE READ AND INITIAL):

Please contact our office 48 hours in advance if you are unable to keep a scheduled appointment. Patients who arrive more than 15 minutes after their scheduled time may be rescheduled and a cancellation fee may be charged. **If you miss a scheduled appointment time, or you fail to cancel/reschedule 48 hours in advance, you may be charged a $50 cancellation fee.** Rescheduled appointments are subject to provider availability and may be disruptive to your care. Initial [_____]

Infusion for Health will invoice you for any outstanding balance once your insurance plans have completed processing your claims. This can take up to 30-45 days for each plan you are covered under. Itemized statements for accounts with no balance owed will be provided upon request only.

I, the undersigned, acknowledge that I have reviewed and understand the financial responsibility policy as stated above. 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.

Patient or Legal Guardian 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 also has the right to request confidential communication or that communication containing 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 HIPAA privacy rule.

Signature of Patient or Authorized Rep: ___________________________Date: ______/_______/______

Please advise with whom may we share your health information directly

Permitted to access PHI:	Relationship:	Name & Phone Number:
No ☐ Yes☐	Spouse/Partner	
No ☐ Yes☐	Parent	
No ☐ Yes☐	Guardian	
No ☐ Yes☐	Child	
No ☐ Yes☐	Other	

Preferred Contact Methods

Method:	Permitted to contact:	Leave Message?	Phone # or other contact
Home Phone	No ☐ Yes☐	No ☐ Yes☐	
Cell Phone	No ☐ Yes☐	No ☐ Yes☐	
Work Phone	No ☐ Yes☐	No ☐ Yes☐	
Email	No ☐ Yes☐	No ☐ Yes☐	

Preferred language: English ☐ Spanish ☐ Other: ___________________________________

Consent to Treatment

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

- I agree to comply with all medically necessary procedures and treatments performed at the center.

I, the undersigned, give 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: I acknowledge that, pursuant to state law, that as patient of this facility I may be tested for the presence of HIV or an HIV antibody without my consent if any health care professional or other city employee sustains percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids. This test is permitted by state law and is for my protection as well as the protection of the physicians, nurses, and other employees of the center. I certify the information I have provided is correct to the best of my knowledge. I will not hold Infusion For Health or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Authorized Rep: ___________________________Date: ______/_______/______

Consent to Share Data

Infusion for Health endeavors to create a more holistic view of patient care. To accomplish this, we have partnered with healthcare experts to bridge data with excellent clinical care. These data partners will never sell patient information, even if identifying information is removed. Infusion For Health will not include your healthcare data without your consent provided below.

I, the undersigned, give authorization to Infusion for Health to provide my healthcare information to our data partners in an effort to continuously improve quality of care. I understand participation is entirely voluntary and in no way impacts my current plan of care.

Printed Name of Patient or Authorized Rep: ________________________________

Signature of Patient or Authorized Rep: ______________________________Date: ______/_______/______

Waiver, Release, and Indemnification

In consideration of my request that Infusion for Health provide medical treatments, infusion therapies, medicines and procedures as are ordered by my Physician and Physician's associates, I hereby agree as follows:

- I understand that Infusion for Health does not provide assistance to patients who are partially ambulatory
- I agree to be accompanied by a custodian, assistant, or helper to aid me when walking, moving, or engaging in any other physical activity while at the Infusion for Health premises, if requested or needed for safety; and
- I understand that the purpose of being accompanied by a custodian, assistant, or helper while walking, moving, or engaging in physical activities is to prevent me from falling or having a similar accident that may cause injury.

In consideration of my request that Infusion for Health provide such treatment, medications and procedures as are ordered by my Physician and my Physician's associates while at the Infusion for Health premises, I hereby agree and shall release and forever discharge Infusion for Health, and its shareholders, members, officers, directors, employees, agents, successors and all other persons acting for, under or in concert with them ("Releasees"), of and from any and all claims, demands, actions, causes of action, obligations, damages, liabilities, losses, costs or expenses, including attorney fees, while walking, moving or engaging in any physical activity at the Infusion for Health premises ("Claims"), suffered or incurred by me or my legal representatives, assigns, distributees, guardians, successors or heirs, whether caused by any negligent act or omission of the Releasees or otherwise, whether such Claims are based on tort, breach of contract, statutory rights, legal or equitable principles. I hereby covenant and agree never to commence or prosecute either individually or on behalf of any other person and/or entity, against Releasees, any action or proceeding based upon the Claims that are the subject matter of this Release.

I hereby agree to indemnify, defend, and hold harmless Releasees from and against any and all Claims asserted by me and my family, friends or any third parties which arise as a result of my or Releasees' negligence, error, or omission. I hereby assume full responsibility for, and the risk of, bodily injury, death, or property damage while at the Infusion for Health premises, whether caused by any negligent act or omission of Releasees or otherwise. I expressly agree that the foregoing Waiver, Release, and Indemnification agreement is intended to be as broad and inclusive as permitted by California law.

If any person, including the undersigned, is a minor, then his or her custodial parent or legal guardian hereby accepts and approves this Release on behalf of such minor person.

I HAVE CAREFULLY READ THIS WAIVER, RELEASE AND INDEMNIFICATION AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN ME AND RELEASEES AND SIGN IT OF MY OWN FREE WILL.

Date: ______________________ ______________________

____
(Patient Name Printed)