Patient Information

Reason for Treatment: _____

Referring Physician: _____ **Date:** _____

PATIENT INFORMATION

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

Sex: ☐ M ☐ F ☐ Prefer Not to Say ☐ 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:** _____

Do you have an Advanced Directive? ☐ Yes ☐ No

If you have an Advanced Directive, please provide Infusion for Health with a copy

INSURANCE INFORMATION

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

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

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

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

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

Your Health Profile

Patient Name: _____

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 bruising
- ☐ 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...

Patient Name: _____

MEDICATIONS / SUPPLEMENTS / VITAMINS

☐ See Attached List

Name:	Dose:	Frequency:

✱ **NONE ☐ (must either list medications or check none)**

Your Health Profile Continued...

Patient Name: _____

INJURIES / ACCIDENTS / SURGERIES

Year: **Description:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SMOKING / DRINKING

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

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

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

Your Health Profile Continued...

Patient Name: _____

ALLERGIES

Allergen:	Description of Reaction:

✱ **NONE ☐ (must either list allergies or check none)**

Your Health Profile Continued...

Patient Name: _____

PERTINENT FAMILY MEDICAL HISTORY

Family Member:	Description:

Patient Assignment

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 and your responsibility to understand your insurance benefits and coverage criteria.

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, and payment is due at the time of service. 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.

Financial Responsibility (PLEASE READ & 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 & 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 _____

IFH PC Financial Policy Continued...

Cancellation Policy (PLEASE READ & INITIAL):

Infusion for Health is committed to providing exceptional care. Unfortunately, cancelations and late arrivals for appointments may affect patient care. Accordingly, please contact our office at 1-888-777-1945 one day prior to your scheduled appointment if you are unable to keep your appointment. If you have a Monday appointment, please contact us on the Friday before. We will do our best to reschedule you, subject to provider availability.

In addition, 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 24 hours in advance, you may be charged a $50 cancellation fee for a missed injection, $100 cancellation fee for a missed infusion.**

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.

Signature: _____ **Date:** _____

For Medicare patients, please sign the ABN on the next page (page 10).
If you are not a Medicare patient, please proceed to page 11.

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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 HIPPA privacy rule.

Signature of Patient or Authorized Rep: _____

Date: _____

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

PERMITTED TO ACCESS PHI:	RELATIONSHIP	NAME & PHONE #
☐ Yes ☐ No	Spouse/Partner	
☐ Yes ☐ No	Parent	
☐ Yes ☐ No	Guardian	
☐ Yes ☐ No	Child	
☐ Yes ☐ No	Other:	

Preferred Contact Methods:

METHOD	PERMITTED TO CONTACT?	LEAVE MESSAGE?	PHONE # OR OTHER CONTACT:
Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	
Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	
Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	
Email	☐ Yes ☐ No	☐ Yes ☐ No	

Consent to Treatment

Patient Name: _____

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 obtained by electronic mail, mail 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 Representative: _____

Date: _____

Consent to Share Data

Patient Name: _____

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 Representative: _____

Signature of Patient or Authorized Representative: _____

Date: _____

Waiver, Release and Indemnification

Patient Name: _____

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.
- I understand it is my duty and responsibility to provide applicable health information before I receive treatment services from Infusion For Health. Failure to provide accurate health information could result in adverse affects to my care and treatment.

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, to the extent permitted under applicable law, I hereby agree and shall indemnify, defend, and hold harmless, 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 ("Claims"), arising out of, or related to, the receipt of my treatment services from Infusion for Health, walking, moving or engaging in any physical activity at the Infusion for Health premises, 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, including reckless conduct, 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.

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 RELEASE, INDEMNIFICATION AND HOLD HARMLESS PROVISION 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 or Authorized Representative Signature)

_____

(Patient Name Printed)

Patient Handouts

Patient Name: _____

☐ I have received a copy of patient handouts that contains: and/or

☐ I have been provided the facility's website address that contains:

- HIPAA Privacy Notice
- Patient Bill Of Rights and Responsibilities
- Emergency Planning, Home Safety, Infection Control
- Making Decisions about Your Health Care
- Grievance / Complaint Reporting.

☐ I have received instructions for medications received. I have received facility marketing material and information on the facility's scope of services. I have received instructions on how to follow up with Infusion for Health.

☐ I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (805) 719-3700 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Leadership. You can expect a written response within 14 working days or receipt.

☐ I understand that I may also make inquiries or complaints about this facility by calling Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at (919) 785-1214.

_____ _____

Patient or Authorized Representative Signature | Date

_____

Patient or Authorized Representative Name Printed

If Beneficiary Unable to Sign:

_____ _____

Witness Signature | Witness Relationship

_____

Reason Patient Unable to Sign