Patient Packet

INFUSION FOR HEALTH

PATIENT INFORMATION

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

Sex: ☐ M ☐ F ☐ Prefer Not To Say **DOB:** _____

Address: _____

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

Email: _____

Home Number: _____ **Mobile Number:** _____

Height: _____ **Weight:** _____

Emergency Contact Name: _____

Relationship: _____ **Emergency Contact Phone:** _____

Do you have an Advance Directive? ☐ Yes ☐ No

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

Do you have a medical power of attorney? ☐ Yes ☐ No **Name:** _____

If you have a medical power of attorney, please provide Infusion for Health with a copy.

Consent to receive text messages: ☐ Yes ☐ No

I understand that text messages are not a fully secure form of communication.

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

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Patient Name: _____

INFUSION FOR HEALTH

HEALTH HISTORY:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Diabetes
- ☐ Stroke/TIA
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Asthma
- ☐ COPD
- ☐ Kidney Disease
- ☐ Autoimmune Disease: _____
- ☐ Neurologic Condition: _____
- ☐ Rheumatological Condition: _____
- ☐ Gastrointestinal Condition: _____
- ☐ Cancer: _____
- ☐ HIV/AIDS
- ☐ Anxiety / Depression
- ☐ Other: _____

MEDICATIONS / SUPPLEMENTS / VITAMINS

☐ NONE (must either list medications or check none) ☐ Additional list attached

Name:	Dose:	Frequency:

ALLERGIES (MEDICATION AND NON-MEDICATION)

☐ NONE (must either list allergies or check none) ☐ Additional list attached

Allergen:	Description of Reaction:

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Patient Name: _____

Insurance and Financial Responsibility

Insurance & Financial Responsibility

Thank you for choosing Infusion for Health—we're here to make your care experience as smooth and stress-free as possible, including helping you understand any costs along the way.

Before your appointment, our team will verify your insurance coverage, benefits, and any required authorizations. If anything is missing or inactive, we'll contact you to review your options. We will confirm these details before services are provided to help avoid unexpected costs.

Infusion for Health will bill your insurance for services provided. However, coverage cannot be guaranteed, and you are responsible for any amounts not covered by your plan. These may include:

- Copayments
- Coinsurance
- Deductibles
- Non-covered services

Payment for your portion may be due at the time of service.

Please notify us if:

- Your insurance changes
- Your contact information changes

While we verify your benefits, final payment decisions are made by your insurance provider. We encourage you to contact them directly with any questions about your coverage.

After your insurance processes your claim (typically within 30–45 days), we will send a statement if there is any remaining balance. Unpaid balances over time may be referred to collections.

Assignment of Benefits

By signing, you authorize your insurance benefits to be paid directly to Infusion for Health for services provided. If your insurance does not cover certain services, you understand that you may be responsible for payment.

Cancellation Policy

If you need to cancel or reschedule, please let us know at least 24 hours in advance. Missed or late-canceled appointments may result in a fee ($50 for injections, $100 for infusions), and arrivals more than 15 minutes late may need to be rescheduled.

By signing, you confirm that you have read and understand this policy and agree to your financial responsibility.

Signature: _____ **Date:** _____

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Patient Name: _____

Consent to Treatment

I authorize Infusion for Health to provide infusion therapy, injections, medications, and related services as ordered by my prescribing provider. I understand and agree to the following:

- My treatment has been ordered by my provider, and Infusion for Health is following their instructions.
- Infusion medications may have risks or side effects that have been discussed with me by my provider.
- I should notify staff immediately if I experience any symptoms or concerns during treatment.
- If my condition requires services beyond those available at this clinic, my provider may arrange additional care.
- I agree to provide accurate and complete information about my health, medications, and allergies.
- I understand that incomplete or inaccurate information could affect the safety of my treatment.
- For safety reasons, patients who require assistance walking or moving will be asked to bring a caregiver as Infusion for Health does not provide ambulatory assistance.
- I agree to follow safety instructions provided by staff during my visit.

Signature of Patient or Authorized Representative: _____

Date: _____

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Patient Privacy, Rights & Acknowledgements

- ☐ I have been provided Notice of Privacy Practices (Included in Packet)
- ☐ I have been informed the Patient Bill of Rights and Responsibilities is posted at: infusionforhealth.com/patient-forms
- ☐ 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, or visit our website's Contact Us form. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance in writing.
- ☐ 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.

Please advise us with whom we may share routine treatment, payment, and operations information

Name:	Relationship:	Phone Number:

By signing below, I agree that Infusion for Health can use and disclose my health information for treatment, payment, health care operations and other purposes described in the Notice of Privacy Practices (attached) as being permissible without written authorization, consistent with HIPAA.

Printed Name of Patient or Authorized Representative: _____

Signature of Patient or Authorized Representative: _____

Date: _____

If Patient Unable To Sign:

Witness Signature: _____ **Witness Relationship:** _____

Reason Patient Unable To Sign: _____

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EFFECTIVE DATE: 07/07/26

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This Notice describes how medical information about you (called Protected Health Information or PHI) may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR PROMISE TO YOU

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required by law to protect the privacy of your PHI, provide this Notice of our legal duties and privacy practices, and follow the terms of the Notice currently in effect.

WHO WILL FOLLOW THIS NOTICE

This Notice applies to all workforce members, volunteers, trainees, contractors, and business associates of Infusion for Health.

HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe ways we commonly use and disclose PHI. We will not use or disclose your PHI for purposes not described here without your written authorization, except as allowed by law. **In all cases, including those listed below,** if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena. We will also comply with any stricter provision required by federal or state laws.

- **For Treatment.** We may use and disclose PHI to provide, coordinate, or manage your infusion treatments and related care. Example: sharing your medication list and treatment plan with nurses, physicians, or pharmacies.
- **For Payment.** We may use and disclose PHI so we can bill and collect payment for the services you receive. Example: providing your insurer with diagnosis and procedure information.
- **For Healthcare Operations.** We may use and disclose PHI for quality assessment, staff training, accreditation, licensing, audits, and other business activities that support patient care.
- **Appointment Reminders & Health-Related Benefits.** We may contact you to remind you of appointments, provide treatment information, or inform you about health-related services or benefits.
- **Treatment Alternatives & Health Programs.** We may inform you about treatment alternatives or programs that might benefit you.
- **As Required by Law.** We will disclose PHI when required by federal, state, or local law.
- **Public Health Activities.** To report disease, injury, vital events, product recalls, or to prevent/control disease.
- **Abuse, Neglect, or Domestic Violence.** To report suspected abuse or neglect when required or permitted by law.
- **Health Oversight Activities.** To agencies for audits, investigations, or inspections.
- **Judicial and Administrative Proceedings.** In response to court orders, subpoenas, or similar legal processes.
- **Law Enforcement.** For certain law enforcement purposes as permitted by law.
- **Family/friends.** We may share PHI with your family, close friends, or others involved in your care or payment for your care or for disaster relief situations if you agree or, when you are incapacitated or unable to agree, we determine it is in your best interests.
- **Research.** For research purposes when an institutional review board or Privacy Board has approved the use, or when PHI is de-identified.
- **Threat to Health or Safety.** To prevent or lessen a serious and immediate threat to the health or safety of a person or the public.
- **Workers' Compensation.** To comply with workers' compensation and similar laws.

OTHER USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Most uses and disclosures of treatment notes, uses of PHI for marketing activities, and disclosures that constitute a sale of PHI require your written authorization. You may revoke an authorization in writing, except to the extent we have acted in reliance on it.

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YOUR RIGHTS REGARDING PHI

You have the following rights. To exercise any of these rights, submit your request in writing to our Medical Records Department at medicalrecordsrequest@infusionforhealth.com. We will respond within the timeframes required by law.

- **Right To Inspect and Copy.** You may request access to inspect or receive a copy of your medical and billing records. We may deny access in limited circumstances; denials may be reviewable.
- **Right To Amend.** You may request an amendment to your PHI if you believe it is incorrect or incomplete. We may deny the request if the record is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures of your PHI we have made (exceptions apply). Requests may be limited to disclosures in the past six years unless state law allows otherwise.
- **Right To Request Restrictions.** You may request restrictions on certain uses and disclosures of your PHI. We are not required to agree to your requested restriction except where you ask us not to disclose PHI to a health plan for payment or healthcare operations and the PHI pertains solely to a service you have paid for out of pocket in full.
- **Right To Request Confidential Communications.** You may ask us to communicate with you by alternative means or at an alternative location (for example, by calling a different phone number). We will accommodate reasonable requests.
- **Right to a Paper Copy of this Notice.** You may request and receive a paper copy of this Notice even if you agreed to receive it electronically.
- **Right To Be Notified of a Breach.** You will be notified if there is a breach of your unsecured PHI, as required by law.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of PHI, provide this Notice, and follow the terms of this Notice. We must promptly notify you if a breach of unsecured PHI occurs.

BUSINESS ASSOCIATES

Some services are provided through contracts with business associates (for example, billing, transcription, or IT services). We require business associates to protect your PHI in accordance with HIPAA through a written business associate agreement.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Infusion for Health or with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). Filing a complaint will not affect your care. To file a complaint with us, contact:

Compliance Officer:

Name: Adam Holland

Email: IFHCompliance@infusionforhealth.com

To file with HHS OCR: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and our privacy practices. Revised notices will be effective for PHI we already have and for PHI we create or receive in the future. The current Notice will be posted and available upon request.

ACKNOWLEDGEMENT OF RECEIPT

You may be asked to sign an acknowledgement that you received or were offered this Notice. Signing does not indicate agreement—only that you received the Notice.

For More Information: If you have questions about this Notice or want more information about our privacy practices, contact the Compliance Officer above.

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