Vegas Valley Infusion Care

Northern Nevada Infusion Care

Patient Intake Form

PATIENT INFORMATION

NEW___ ESTABLISHED___

How did you hear about us? _____

If referred, who referred you?_____

Patient Name: (Last, First, MI)_____ **Date of Birth:**

Gender: **Male / Female** **Social Security Number:**

Address: **Apt:** **City:** **State:** **Zip Code:**

Mailing Address (If different from above)

Address: **Apt:** **City:** **State:** **Zip Code:**

Home Phone : **Cell :** **Work Number:**

Email: **May we contact you via e mail** **Yes** **No**

EMERGENCY CONTACT INFORMATION

Name: **Relationship To Patient:** **Phone Number:**

INSURANCE INFORMATION

Primary Insurance: **Plan:** **Effective Date:**

Policy Number: **Group Number:** **HMO:** **PPO:** **POS:**

Secondary Insurance: **Plan:** **Effective Date:**

Policy Number: **Group Number:** **HMO:** **PPO:** **POS:**

PHARMACY

Pharmacy: **Pharmacy Phone:**

Pharmacy Address: **City:** **State:** **Zip Code:**

ALLERGIES

Drug Allergies : (Please List)

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment, and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to INFUSION CARE LLC as indicated in the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage. I understand that deductibles, copayments, and non-covered services are my responsibility.

_____ _____

PATIENT NAME (PRINT) **PATIENT SIGNATURE** **DATE**

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Medical History Form 2026

Patient Name: **Date of Birth:**

1) **Date of Most Recent Hospitalization (**If Applicable**):** **or N/A (skip to question 2)**

Reason for Hospitalization:

A. **Have you had a recent illness and/or infection in the last 30 days?: (Yes) (No)**

If Yes, explain :

B. **Have you had any surgeries?: (Yes) (No)**

If Yes, please list type and year:

2) **Any allergies to medications, food items, etc.?: (Yes) (No)**

If Yes, please list :

3) **Are you currently pregnant or breastfeeding?: (Yes) (No) (N/A)**
4) **Do you have a history of seizures (Yes) (No) if yes what type**
5) **Have you ever been diagnosed with COVID, (No) (Yes) if so what date:**
6) **Please check any other pertinent medical information:**

Hypertension Diabetes Thyroid Disorder Asthma/COPD Autoimmune Disorder Dialysis Cancer (type:) Bleeding Disorder Kidney Disease Liver Disease Stroke/TIA Heart Disease Arrhythmias/Atrial fibrillation Pacemaker/Defibrillator Anxiety/Depression Other:

7) **Estimate of Your General Health: (Poor) (Fair) (Good) (Excellent)**
8) **Please list any medications you are currently taking:**

Medication name	Dose	Frequency/Time of day	Purpose

Date of completion:

Infusion Care, LLC

Financial Policy

Effective January 1, 2026

Patient Name: /DOB:

Thank you for choosing Infusion Care, LLC as your health care provider. Please carefully read and initial by each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to ensure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you. PLEASE INITIAL EACH LINE BELOW.

1. _____ I understand that if I do not have my insurance card, referral, and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Infusion Care, LLC will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and INFUSION CARE LLC. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company. Refunds are issued after final adjudication by the insurance carrier.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.) Infusion Care, LLC accepts cash, check, debit card, and major credit cards. I understand that if a credit card is utilized for payment, a 3% processing fee may be added, if necessary.

4. _____ I understand that if I am unable to make a scheduled appointment, I need to contact INFUSION CARE LLC at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. **A $25 FEE MAY BE ASSESSED FOR ALL MISSED APPOINTMENTS AND $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE**.

5. _____I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____Infusion Care, LLC will allow 90 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 90 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify INFUSION CARE LLC if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by INFUSION CARE, LLC.

Signature of Responsible Party: Date:

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to INFUSION CARE LLC.
I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: INFUSION CARE, LLC. This assignment will remain in effect until revoked by me in writing. Any and all Blue Cross Blue Shield insurance plans have permission of below signed party to forward payment of said claims directly to INFUSION CARE LLC at its corporate location of 8530 W. Sunset Road, Suite 240, Las Vegas, NV 89113. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: Date:

Vegas Valley Infusion Care

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Patient Name: **/DOB:**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

For Treatment, Payment, and Healthcare Operations (HIPAA)

I , understand that as part of my health care, Infusion Care, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer(s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and will be provided, upon request, with a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review said Notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that Infusion Care, LLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may, as permitted by Section 164.520 of the Code of Federal Regulations, be unable to provide non-emergent services.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (i.e. insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email. I understand that electronic communications (including email or fax) may carry certain privacy risks, and I consent to such methods when necessary for care coordination and billing.

In addition, I also give consent to Infusion Care, LLC to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

X_____
Patient/ Legal Guardian Signature Date

Infusion Care, LLC – Medical Records Release Authorization Form

Patient Name: Date of Birth:

SSN:

Address: Primary Phone:

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below whom I am authorizing to use and/or disclose my health information may not condition treatment, payment, and enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

1. **I authorize INFUSION CARE LLC to use/disclose certain protected health information.**
2. **I authorize the following health information to be used and/or disclosed:**

History & Physical	Last visit note(s)/progress note(s)
Diagnostic reports	Most recent labs/ culture reports
Medication list(s)	Radiology reports
Last infusion summary report	PICC line information

Other:

3. **I authorize the following persons/organizations to receive and/or use my health information: INFUSION CARE LLC VIA FASCIMILE AT (702) 998-4445.**
4. **I authorize my health information to be used and/or disclosed for the following purpose(s): CONTINUITY OF CARE.**
5. **I authorize my health information be released by the following provider(s)/organization(s):**

Physician(s)/Organization(s) Name: Phone:
Fax:

Address: City: State: Zip:

6. **Expiration of Authorization: This authorization will be effective as of (date) and will remain in effect until the following date or event:**
7. **My Right to Revoke This Authorization: I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing.**

_____

PATIENT SIGNATURE **DATE**

WITNESS SIGNATURE: _____ **DATE**:

IF PATIENT IS UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is unable to sign because:

Name of personal representative and relationship to patient:

Address: / Home/Cell telephone #:

_____

SIGNATURE OF PERSONAL REPRESENTATIVE **DATE**

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