___ 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: (circle one) **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 on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

PATIENT NAME (PRINT)	PATIENT SIGNATURE	DATE

Medical History Form

Patient Name: _____ **Date of Birth:** _____

Date of Most Recent Hospitalization (If Applicable): _____ **or N/A (skip next question)**

Reason for Hospitalization:

_____

Estimate of Your General Health: **(Poor)** _____ **(Fair)** _____ **(Good)** _____ **(Excellent)** _____

Do You Have or Have You Ever Had:

1. **Hospitalization for illness or injury?: (Yes)** _____ **(No)**_____

If Yes, explain :_____

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

If Yes, please list : _____

3. **Any medical problems regarding the heart, kidneys, or liver?:** **(Yes)** _____ **(No)** _____

If Yes, explain: _____

_____

_____

4. **Are you currently pregnant or breastfeeding?: (Yes)** _____ **(No)** _____
5. **Please list any other pertinent medical information:**

_____

_____

_____

6. **Please list any medications you are currently taking:**

Drug	Purpose

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO 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 pf Healthcare professionals

I understand and have been provided with a *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 the 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 options

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 refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

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 (Insurance company, referring physician, consulting physician, hospital, ect.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

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

Intravenous (IV) Consent Form

This document shall serve as confirmation of informed consent for intravenous (IV) therapy as ordered by your physician. Your IV therapy will be administered by a registered nurse under supervision of a practitioner licensed in the State of Nevada.

Intravenous (IV) Therapy Definition

Intravenous (IV) therapy is a therapy that delivers liquid substances directly into a patient's vein. This route of administration is used for injections or infusions. IV therapy is the fastest method for fluid replacement, correction of electrolyte imbalances, medication delivery and blood transfusions.

Acknowledgements

_____ I have informed practitioner of any known allergies to drugs or other substances.
_____ I have informed practitioner of any past reactions to anesthetics.
_____ I have informed practitioner of all medications and supplements I am currently taking.

I understand that I have the right to be informed of the procedure, alternatives to the procedure, and the risks and benefits associated with the procedure. Procedures at Infusion Care, LLC will not be performed unless I have been given the opportunity to receive such information and provide my informed consent, except in case of emergency.

I hereby acknowledge that I understand:

- This procedure involves inserting a needle into a vein, through which a prescribed solution will be injected or infused
- Alternatives to intravenous therapy consist of dietary and lifestyle changes, ad/or oral supplementation

Risks Associated with Intravenous Therapy

Discomfort, bruising and pain at site of injection
Inflammation of vein used for injection, phlebitis
Metabolic disturbances
Injury
Allergic reaction (can be severe)
Anaphylaxis
Infection
Cardiac arrest

Benefits of Intravenous Therapy

Injectables are not affected by typical digestive problems
Entirety of infused substance available to tissues
Nutrients are rapidly delivered to the body's cells
Higher doses of nutrients than by oral route

I am aware that unforeseeable complications may occur during this procedure. I do not expect the supervising physician to anticipate and/or explain all such complications or potential risks. I will defer to the supervising physician, and other healthcare professionals at Infusion Care, LLC when exercising their professional judgement during unforeseen circumstances regarding my infusion treatment.

I understand that I have the right to consent to, or refuse, any treatment at any time prior to its performance. My signature on this form shall affirm I have provided informed consent to IV therapy.

The risks and benefits have of this procedure have been explained to me, and I have had the opportunity to ask questions.

I understand the information provided on this form and agree that the procedure set forth above has been adequately explained to me.

I authorize and consent to this procedure.

Patient Name _____ **DOB** _____

Patient Signature _____ **Date** ____/____/_____

_____ **Date** ____/____/_____

RN OR PRACTITIONER WITNESS SIGNATURE

Infusion Care, LLC

Financial Policy

Effective January 1, 2020 Patient Name:_____

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 assure 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.

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 Vegas Valley Infusion Care and Northern Nevada Infusion Care. 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.
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.)
4. _____ I understand that if I am unable to make a scheduled appointment, I need to contact Vegas Valley Infusion Care or Northern Nevada Infusion Care 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 WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $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 60 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 60 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 PRACTICE NAME 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 clinic.
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. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where 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:

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
   - ☐ Diagnostic reports
   - ☐ Medication list(s)
   - ☐ Last infusion summary report
   - ☐ Last visit note(s)/progress note(s)
   - ☐ Most recent labs/ culture reports
   - ☐ Radiology reports
   - ☐ 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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