Infusion
WELLNESS CENTER

Patient Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

Patient _____ Date of Birth _____ Sex _____

Address _____ City, State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Responsible Party _____ Date of Birth _____ Sex _____

Only fill out if different from above

Address _____ City, State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_____Spouse_____Child_____Other _____

Relative or friend in case of emergency _____
Name Phone # Relationship

Source of referral (if applicable) _____ Reason for referral _____

How did you hear about Infusion Wellness Center?_____

FINANCIAL

I understand that Infusion Wellness Center does not accept insurance. Upon request, I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed the entire amount of the appointment. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

OVER

Patient Intake Form

Practice Policies

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:

    a) If IV Therapy is an appropriate treatment option
    b) Frequency of IV Therapy infusion sessions
    c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment varies in length depending on your chief complaint. Typically, 40 min infusion appointments take just under 2 hours, 4-hour infusions are typically around 5 hours in length. At the end of each appointment, you can make arrangement for your next appointment or you may also book all your prescribed appointments at once.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full for each office prior to the start of your appointment. If you do not have a charge card. We will accept cash and check. Please make checks out to "Infusion Wellness Center".

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how treatment will be paid for.
We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in by giving you receipts to submit. Some insurance companies will pay for a portion of outpatient IV Therapy infusion services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Infusion Wellness Center are ultimately your responsibility. If your insurance company requires that outpatient IV Therapy infusion services be preauthorized, it is your responsibility to initiate the preauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient health services will result in you being held 100% responsible for all charges.

6. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at Infusion Wellness Center and is considered confidential within the office unless specified by you in writing. However, each provider at this office reserves the right to use specialty consultation with other medical providers at the office as deemed necessary. We follow HIPAA and maintain confidentiality.

Please initial boxes.

_____Yes _____No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

_____Yes _____No I have received a copy of the Privacy Practices Form.

_____Yes _____No I consent to the exchange of treatment information between Infusion Wellness Center and my primary care or mental health provider.

I have personally reviewed and completed this entire document and the information I provided herein is true and accurate.

Patient's Printed Name:_____

Patient's Signature: _____ Date: _____