Island IV, LLC
VI Medical Foundation Building
9150 Estate Thomas, Suite 203B
St Thomas, USVI 00802-2612

Intake Form

Today's Date:_____

Name: _____Date of Birth: _____

Age: _____ Sex: M / F

Allergies: _____

Address:_____

Phone (cell or home or work):_____ Email address: _____

In case of emergency, please contact:

Name:_____ Phone:_____

How did you hear about us?_____

What are your main complaints? *(Please check all that apply)*

- ☐ Fatigue or low energy ☐ Stress
- ☐ Poor diet due to busy lifestyle ☐ Headaches or migraines
- ☐ Brain fog or trouble concentrating ☐ Low mood or depression
- ☐ Weight gain or difficulty losing weight ☐ Slow metabolism
- ☐ Asthma and Allergies ☐ Recent surgical procedure
- ☐ Recent illness ☐ Cold or flu symptoms
- ☐ Dull or dry skin ☐ Malabsorption issues
- ☐ Cancer
- ☐ Other_____

Which statements best describe why you are here today? (Please check all that apply)

- ☐ I want to have more energy and feel better overall ☐ I want to do everything I can to nourish my body
- ☐ I want to do everything I can to enhance my weight loss efforts
- ☐ I want to prevent getting sick _____
- ☐ I want to recover quickly from my surgery or illness ☐ I want to slow the aging process
- ☐ I want to feel and look younger ☐ I want to have smoother, brighter and more vibrant skin
- ☐ I want to cleanse my body of toxins ☐ I want to recover quickly from a hangover
- ☐ Other _____

(Females only) Are you pregnant or breastfeeding? Yes / No

Date of last labs or other lab testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(Please check all that apply)

- ☐ Hypermagnesemia (High magnesium levels) ☐ B12 deficiency ☐ Vitamin D deficiency
- ☐ Antioxidant deficiency such as Glutathione ☐ Hypercalcemia (High calcium levels)
- ☐ Hypokalemia (Low potassium levels) ☐ Hemochromatosis (High iron levels)
- ☐ Other _____

Are you a smoker? Yes / No If Yes, how much do you smoke and for how long?_____

How many alcoholic drinks do you consume in a week? _____

Do you use any recreational drugs? Yes / No If Yes, which ones and how often? _____

Prescription Medications – Strength – Frequency

_____

_____

Over the Counter Drugs – Strength – Frequency

_____

_____

Vitamins and Other Supplements – Strength – Frequency

_____

_____

Do you take Digoxin (Lanoxin) or Coumadin (Warfarin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes: _____

Do you take any steroids, i.e. Prednisone? Yes / No If Yes: _____

Do you have any medication or food allergies? Yes / No If Yes: _____

Do you have any of the following conditions? (Please check all that apply)

☐ Blood pressure problems (High or low) ☐ Heart Problems, if so, _____

☐ Stroke or "mini-stroke" ☐ Kidney Problems ☐ Diabetes (1 or 2?) ☐ Kidney Stones

☐ Autoimmune Condition(s) ☐ Cancer ☐ Sickle Cell Anemia ☐ G6PD Deficiency ☐ Parathyroid problems

List any other medical conditions you have (not mentioned above):

_____

List of all surgical procedures you've had with approximate dates:

_____

FINANCIAL

I understand that insurance **WILL NOT** be accepted for nutrient infusions. Payment can be made in the form of Cash, Check, Money Order or PayPal, Venmo and Cash App. I will be given a receipt after each payment. I have been given the opportunity to ask questions regarding this statement.

Signature of Responsible Party:_____

Printed Name of Responsible Party:_____

Date:_____

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

2. APPOINTMENTS: Each appointment varies in length depending on the nutrient and dose. At the end of each appointment you can make arrangements 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.

4. PAYMENTS: We would greatly appreciate payment in full for each visit prior to the start of your appointment. WE WILL ACCEPT CASH, CHECK, MONEY ORDERS, Venmo (@islandivhydration), CASH APP($IslandIV) and PAYPAL (@islandivhydration). PLEASE MAKE CHECKS OUT TO “ISLAND IV”.

5. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at At our office and is considered confidential within the office unless specified by you in writing. We follow HIPAA and maintain confidentiality.

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. Initial_____

I consent to the exchange of treatment information between Island IV LLC and my primary care or mental health provider. Initial_____

Patient(s):_____

Physician’s Name/Office & Phone Number:_____

Sign & Date:_____

COVID-19 Questionnaire

Please review and respond to the following questions.

Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?

_____

Have you or anyone in your household been tested for COVID-19? _____

What was the result? _____

Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?

_____

Have you or anyone in your household traveled in the U.S. in the past 21 days? _____

Have you or anyone in your household traveled on a cruise ship in the last 21 days?_____

Are you or anyone in your household a health care provider or emergency responder? _____

Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?

_____

Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?

_____

To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?

_____

If you have answered "Yes" to any questions, please contact us prior to your appointment.

HIPAA NOTICE OF PRIVACY PRACTICES

Island IV and its medical staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protect your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This HIPAA notice applies to all of the records of your care generated by us, and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

* Make sure that health information that identifies you is kept private
* Give you this Notice of our legal duties and privacy practices with respect to health information about you
* Follow the terms of the Notice that is currently in effect

How we may use and disclose health information about you:

* For Treatment
* For Payment
* For Healthcare operations
* For appointment reminders
* As required by law
* Public Health risks
* Health oversight activities
* Lawsuits and disputes
* Law enforcement
* To avert a serious threat to health and safety
* As required by the Military or Veterans and Workers Compensation
* Coroners, health examiners and funeral directors
* National Security and Intelligence activities
* Protective Services for the President and others
* Security Officials for Inmates

Your rights regarding Health Information about you:

* Right to inspect and copy
* Right to Amend
* Right to Accounting of Disclosures
* Right to Request Restrictions
* Right to Request Confidential Communication

Your medical records:

The original copy of your and/or electronic medical record is the property of Island IV. You may request a copy of your records to be transferred by completing a medical records release form. We require 14 business days from the date of your request to prepare and send your records unless the records are for urgent of life threatening health issues.

Changes to this notice:

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.

Permission to share your health information: We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.

Name:_____

Phone # s):_____

Acknowledgement of receipt of the Island IV HIPAA Notice of Privacy Practices: We request that you sign this form acknowledging you have received, read, and reviewed the Island IV HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient.This acknowledgement will become part of your records. Thank you for your cooperation.

Signature of Patient _____

Consent Form

I, _____, DOB _____/_____/_____ , hereby authorize the following procedure: administration of intravenous/intramuscular vitamins,minerals, and other nutrients.

(Initials)_____ I have informed the physician of any known allergies to drugs or other substances, or of any past reactions to medications.

(Initials)_____ I have informed the provider of all current medications and supplements.

(Initials)_____ I, understand that I have the right to be informed ofthe procedure, any feasible alternative options, and the risks and benefits.

Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

Side Effects/Risks

(Initials)_____

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
    a. Occasionally to commonly:
        i. Discomfort, bruising and pain at the site of injection.
        i. General feeling of warmth during and after injection.
    b. Rarely:
        i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
        ii. Reactive Hypotension (or rapid drop in blood pressure)
        ii. Reactive Hypoglycemia (or rapid drop in blood sugar)
    c. Extremely Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

Benefits of intravenous therapy include:

1. Injectables are not affected by stomach, or intestinal absorption problems.
2. Total amount of infusion is available to the tissues.
3. Nutrients are forced into cells by means of a high concentration gradient.
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

The Procedure

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids). Your vitals will be measured prior to and after your infusion.

Intramuscular injections involves inserting a needle in the muscular (deltoid, thigh or gluteal) for the injections of prescribed nutrients.

What Safety Precautions Must You Take?

- Monitor the insertion site for signs and symptoms of infection (redness, swelling, discharge). Notify the clinic immediately. If your experience a sustained fever greater than 101, do not delay treatment and go to the ER as this can be a sign of sepsis.
- If you experience a minor side effect while you are at home, you should contact the Nurse, otherwise contact your medical provider or call 911.

My Consent for Nutrient Infusion Therapy is Voluntary

My request for nutrient infusion therapy as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse treatments at any time.

(Initials)_____

Statement of Person Giving Informed Consent

I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction. I am aware that other unforeseeable complications could occur. I do not expect the provider(s) to anticipate and or explain all risk and possible complications. I rely on the provider(s) to exercise judgment during the course of treatment with regards to my procedure.

I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I give my consent to IV nutrient therapy.

_____ _____

Signature of Patient Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical records, to EMS, my spouse, and emergency contact. I also authorize the provider to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns.

_____ _____

Signature of Patient Date

Copy Provided_____