Patient Information

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

Reason for Treatment: _____

Referring Physician: _____ **Date:** _____

PATIENT INFORMATION

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

Sex: ❒ M ❒ F ❒ Prefer Not to Say ❒ Other **Marital Status:** ❒ Married ❒ Single ❒ Divorced ❒ Widowed

DOB: _____ **Social Security #:** _____

Address Street: _____

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

Email: _____

Home #: _____ **Mobile:** _____

Driver's License #: _____ **Height:** _____ **Weight:** _____

Occupation: _____ **Work #:** _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____ **Email:** _____

INURANCE INFORMATION

Primary Insurance Company: _____ **Policy #:** _____

Holder Name: _____ **Holder DOB:** _____

Secondary Insurance: _____ **Policy #:** _____

Holder Name: _____ **Holder DOB:** _____

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

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Tel: 818-659-8182
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Your Health Profile

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Patient Name: : _____

HEALTH HISTORY:

Cardiovascular

- ❒ High Blood Pressure
- ❒ Low Blood Pressure
- ❒ Congestive Heart Failure
- ❒ Heart Attack
- ❒ Stroke/TIA
- ❒ Pacemaker or Defibrillator
- ❒ Heart Disease
- ❒ A-Fib
- ❒ Other: _____

Diabetes/Thyroid

- ❒ Diabetes
  - ❒ Type I ❒ Type II
- ❒ Thyroid Disease
  - ❒ Hyper ❒ Hypo
- ❒ Grave's Disease
- ❒ Other: _____

Neurology

- ❒ Multiple Scterosis
- ❒ Myasthenia Gravis
- ❒ Seizures
- ❒ Migraines
- ❒ Parkinson's Disease
- ❒ Heart Disease
- ❒ Stroke
- ❒ Other: _____

Immune System

- ❒ Allergic Rhinitis
- ❒ C I D P
- ❒ Primary Immunodeficiency
- ❒ Systemic Lupus Erythematosus
- ❒ Other: _____

Respiratory

- ❒ C O P D
- ❒ Chronic Cough
- ❒ Bronchitis
- ❒ Asthma
- ❒ Emphysema
- ❒ Other: _____

Skin Conditions

- ❒ Eczema
- ❒ Psoriasis
- ❒ Hives/Urticaria
- ❒ Other: _____

Musculoskeletal

- ❒ Osteoporosis
- ❒ Loss of sensation. tingling. numbness
- ❒ Other: _____

Blood/Immune/Cells

- ❒ Iron deficincy anemia
- ❒ Hemophilia
- ❒ Easy bruising
- ❒ HIV/AIDS
- ❒ Other: _____

Rheumatology

- ❒ Gout
- ❒ Rheumatology
- ❒ Plaque Psoriasis
- ❒ Psoriatic Arthritis
- ❒ Other: _____

Women

- ❒ Currently pregnant
- ❒ Hyperemesis
- ❒ Endometriosis
- ❒ Fibroids
- ❒ Other: _____

GI

- ❒ Crohn's Disease
- ❒ Ulcerative Colitis
- ❒ GERD/reflux
- ❒ Other: _____

GU/Chronic KIdney Disease

- ❒ Stage 1 ❒ Stage 2
- ❒ Stage 3 ❒ Stage 4
- ❒ Dialysis

Psychological

- ❒ Anxiety
- ❒ Depressions
- ❒ Other: _____

Cancer

- ❒ Breast
- ❒ Prostate
- ❒ Other: _____

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Your Health Profile Continued...

Patient Name: : _____

MEDICATIONS / SUPPLEMENTS / VITAMINS

❒ See attached List

Name:	**Dose :**	**Frequency :**

SMOKING / DRINKING

Smoker? ❒ No ❒ Yes **Former Smoker?** ❒ No ❒ Yes **Pks/day:** _____ **Age Quit:** _____

Drink Alcohol? ❒ No ❒ Yes **Type?** ❒ Wine ❒ Beer ❒ Other **Drinks per week:** _____

Drink Caffeine? ❒ No ❒ Yes **Cups per week:** _____

Your Health Profile Continued...

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Patient Name: : _____

INJURIES / ACCIDENTS / SURGERIES

Year:	**Description :**

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Your Health Profile Continued...

Patient Name: : _____

ALLERGIES

Allergen:	**Description of Reaction :**

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Your Health Profile Continued...

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Patient Name: : _____

PERTINENT FAMILY MEDICAL HISTORY

Family Member:	**Description:**

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Patient Assignment

SMART CHOICE INFUSION
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Thank you for choosing Smart Choice Infusion. We are committed to providing you with the best possible care, including assisting our patients with understanding their financial responsibilities as it relates to the prescribed services. To ensure that you are familiar with our financial policies please read this document thoroughly and initial or sign where indicated.

Prior to your appointment. Smart Choice Infusion staff will contact your insurance company to verify eligibility. coverage, and benefits. If active coverage is not available, Smart Choice Infusion staff will contact you to review payment options for prescribed services. If prior authorization is required by your insurance plan, Smart Choice Infusion staff will contact the insurance company to request authorization for services. To protect you from unexpected charges, services will not be rendered until we have verified active coverage and obtained any required prior authorization, or until we obtain a signed private payment agreement from you. Please remember to notify us prior to your next appointment of any insurance changes, such as when you change health plans, change employers, or your company offers a different health benefit plan.

Coverage, eligibility, and benefits are based on information provided by your insurance company. Checking coverage, eligibility, benefit information, and/or the fact that a service has been pre authorized is not a guarantee of payment Benefits will be determined by your insurance company once a claim has been received. We encourage you to confirm this information directly with your insurance company. Your Insurance carrier may need you to supply certain information directly. It is your responsibility to comply with their requests.

Smart Choice Infusion is a participating provider with many commercial, Medicare, and Medicaid insurance carriers including managed care plans. We will bill the insurance carriers directly. You will be responsible for your share of cost as assigned by your insurance plan. These costs may include co payments, coinsurance and/or deductible payments. Enrollment in a medication co-pay assistance program is the only exception to the share of cost policy. All health plan payments should be directed to Smart Choice Infusion for direct payment. You should notify Smart Choice Infusion immediately if health plan payments are made payable to you in error.

Our practice will not waive, fail to collect, or discount coinsurance, deductibles, or other patient financial responsibilities in accordance with state and federal law, as well as participating agreements with payers.

Financial Responsibility (PLEASE READ & INITIAL):

I acknowledge that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, coinsurance, and non- covered services, as dictated by my insurance coverage. I acknowledge that if any services provided by Smart Choice Infusion are not covered by my insurance plan for one or more reasons, including but not limited to, exclusions from my insurance plan or funding limits with my insurance plan, out-of-network provider, and/or failure to provide updated insurance information, I will be responsible for the full charge of all services. I acknowledge that **cancellation** fees are not billed to insurance carriers, and I agree to be financially responsible for those fees.

Initial _____

To ensure you are not billed in error you must inform Smart Choice Infusion of any active Medi-Cal or Medicaid coverage prior to services being rendered.

Assignment of Benefits (PLEASE READ & INITIAL):

I hereby assign all benefits of my insurance and other funding sources to Smart Choice Infusion for services rendered. I accept financial responsibility for all charges if I do not have medical insurance or if my medical insurance does not reimburse Smart Choice Infusion for services provided. I understand that the services provided may not be covered by my insurance plan and that my insurance may assign to me a share of cost. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

Initial _____

Financial policy Continued...

SMART CHOICE INFUSION
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Cancellation Policy (PLEASE READ & INITIAL):

Please contact our office 48 hours in advance if you are unable to keep a scheduled appointment. Patients who arrive more than 15 minutes after their scheduled time may be rescheduled and a cancellation fee may be charged. **If you miss a scheduled appointment time, or you fail to cancel/reschedule 48 hours in advance, you may be charged a $50 cancellation fee.** Rescheduled appointments are subject to provider availability and may be disruptive to your care.

Initial _____

Smart Choice Infusion will invoice you for any outstanding balance once your insurance plans have completed processing your claims. This can take up to 30-45 days for each plan you are covered under. Itemized statements for accounts with no balance owed will be provided upon request only.

I, the undersigned, acknowledge that I have reviewed and understand the financial responsibility policy as stated above. If my account balance becomes overdue and is placed with a collection or legal agency. I agree to pay all attorney or collection agency fees associated with my delinquent account.

Signature: _____ **Date:** _____

HIPAA Privacy Practice

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Patient Name: : _____

HIPAA privacy rules give individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual also has the right to request confidential communication or that communication containing PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

My signature below constitutes my acknowledgment that I have been advised of the HIPPA privacy rule.

Signature of Patient or Authorized Rep: _____

Date: _____

Please advise us with whom we may share your information directly.

PERMITTED TO ACCESS PHI:	RELATIONSHIP	NAME & PHONE #
❒ Yes ❒ No	Spouse/Partner	
❒ Yes ❒ No	Parent	
❒ Yes ❒ No	Guardian	
❒ Yes ❒ No	Child	
❒ Yes ❒ No	Other:	

Preferred Contact Methods.

METHOD	PERMITTED TO CONTACT?	LEAVE MESSAGE?	PHONE # OTHER CONTACT:
Home Phone	❒ Yes ❒ No	❒ Yes ❒ No	
Cell Phone	❒ Yes ❒ No	❒ Yes ❒ No	
Work Phone	❒ Yes ❒ No	❒ Yes ❒ No	
Email	❒ Yes ❒ No	❒ Yes ❒ No	

Consent to Treatment

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Patient Name: : _____

I hereby request the services of Smart Choice Infusion, and I consent to treatment, medications, and procedures as ordered by my physician and my physician's associates. I agree that Smart Choice Infusion is not liable for any act or omission when following a physician's instructions. I also understand that if I am in a condition to need hospitalization or special services during the course of my care, these services are not provided by Smart Choice Infusion and must be arranged by me, my legal guardian/representative or my physician.

- I agree to comply with all medically necessary procedures and treatments performed at the center.

I, the undersigned, give authorization to Smart Choice Infusion, to obtain any of my medical records, mailed or faxed, pertinent to my medical condition. Authorization to Test and Release Information: I acknowledge that, pursuant to state law, that as patient of this facility, I may be tested for the presence of HIV or an HIV antibody without my consent if any health care professional or other city employee sustains percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids. This test is permitted by state law and is for my protection as well as the protection of the physicians, nurses, and other employees of the center. I certify the information I have provided is correct to the best of my knowledge. I will not hold Smart Choice Infusion or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Authorized Representative: _____

Date: _____

Consent to Share Data

SMART CHOICE INFUSION
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Patient Name: : _____

Smart Choice Infusion endeavors to create a more holistic view of patient care. To accomplish this, we have partnered with healthcare experts to bridge data with excellent clinical care. These data partners will never sell patient information, even if identifying information is removed. Smart Choice Infusion will not include your healthcare data without your consent provided below.

I, the undersigned, give authorization to Smart Choice Infusion to provide my healthcare information to our data partners in an effort to continuously improve quality of care. I understand participation is entirely voluntary and in no way impacts my current plan of care.

Printed Name of Patient or Authorized Representative: _____

Signature of Patient or Authorized Representative: _____

Date: _____

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Waiver, Release and Indemnification

Patient Name: : _____

In consideration of my request that Smart Choice Infusion provide medical treatments, infusion therapies, medicines and procedures as are ordered by my Physician and Physician's associates, I hereby agree as follows:

- I understand that Smart Choice Infusion does not provide assistance to patients who are partially ambulatory
- I agree to be accompanied by a custodian, assistant, or helper to aid me when walking moving, or engaging in any other physical activity while at the Smart Choice Infusion premises, if requested or needed for safety; and
- I understand that the purpose of being accompanied by a custodian, assistant, or helper while walking, moving, or engaging in physical activities is to prevent me from falling or having a similar accident that may cause injury.

In consideration of my request that Smart Choice Infusion provide such treatment, medications and procedures as are ordered by my Physician and my Physician's associates while at the Smart Choice Infusion premises, I hereby agree and shall release and forever discharge Smart Choice Infusion, and its shareholders, members, officers, directors, employees, agents, successors and all other persons acting for, under or in concert with them
("Releasees"), of and from any and all claims, demands, actions, causes of action, obligations, damages, liabilities, losses, costs or expenses, including attorney fees, while walking, moving or engaging in any physical activity at the Smart Choice Infusion premises Claims) suffered or incurred by me or my legal representatives, assigns, distributees, guardians, successors, or heirs, whether caused by any negligent act or omission of the Releasees or otherwise, whether such Claims are based on tort, breach of contract, statutory rights, legal or equitable principles. I hereby covenant and agree never to commence or prose cute either individually or on behalf of any other person and/or entity against Releasees, any action or proceeding based upon the Claims that are the subject matter of this Release.

I hereby agree to indemnify, defend, and hold harmless Releasees from and against any and all Claims asserted by me and my family, friends or any third parties which arise as a result of my or Releasees' negligence, error, or omission. I hereby assume full responsibility for, and the risk of, bodily injury, death, or property damage while at the Smart Choice Infusion premises, whether caused by any negligent act or omission of Releasees or otherwise. I expressly agree that the foregoing Waiver, Release, and Indemnification agreement is intended to be as broad and inclusive as permitted by California law.

If any person, including the undersigned, is a minor, then his or her custodial parent or legal guardian hereby accepts and approves this Release on behalf of such minor person.

I HAVE CAREFULLY READ THIS WAIVER, RELEASE AND INDEMNIFICATION AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN ME AND RELEASEES AND SIGN IT OF MY OWN FREE WILL

Date: _____

_____
(Patient or Authorized Representative Signature)

_____
(Patient Name Printed)