EAST COAST IV

Health Questionnaire and Medical History

Patient information

Date:_____

Name:_____ _____ _____

Last First Middle

Address: _____ Apt:_____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email: _____

Date of birth: _____ Age: _____ Sex: Male Female

How did you hear about us? _____

Emergency Contact

Name:_____ Phone: _____ Relationship: _____

Patient Confidential Medical History

Have you been treated by a physician within the past year for any health conditions? Yes No

If yes, please describe:_____

Current medications: _____

_____

Are you allergic to any medications? _____

Have you had any past surgeries? If so, please list: _____

Is it possible you could be pregnant? _____ Are you currently breastfeeding? _____

Has anyone in your family died suddenly while performing athletic activities or for an unknown cause?

If yes, please explain: _____

Reason for IV infusion

What are your present complaints? _____

Are you in any pain? _____ Where? _____ How long? _____

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Patient Confidential
Medical History

Please check **all** that apply

Respiratory

☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Sinus Disease
☐ COPD
☐ Emphysema
☐ Tuberculosis
☐ Shortness of Breath

Musculoskeletal

☐ Arthritis
☐ Joint Problems
☐ Bone Problems
☐ Muscular Dystrophy

Digestive System

☐ Ulcer
☐ Acid Reflux
☐ Nausea
☐ Vomiting

Neurologic

☐ Headaches
☐ Migraines
☐ Concussion
☐ Dizziness
☐ Numbness/Tingling
☐ Epilepsy/Seizures
☐ Weakness
☐ Fainting
☐ Balance Problems
☐ Paralysis
☐ Depression
☐ Anxiety
☐ Psychiatric Disorder
☐ Multiple Sclerosis
☐ Leber's Hereditary Optic Neuropathy

Genitourinary System

☐ Urinary Retention
☐ Kidney Disease
☐ Bladder Disease
☐ Prostate Disease/BPH
☐ Menstrual Problems

Other

☐ HIV/AIDS
☐ Hepatitis
☐ Diabetes
☐ Cancer
☐ Thyroid Disease
☐ Other: _____

EAST COAST IV

Contract for services

I consent to East Coast IV, LLC providing to the patient named below (the "patient") such professional medical treatment and such goods and services as they may determine to be necessary or appropriate.

I acknowledge that the medical history I have provided to East Coast IV, LLC and its employees is honest and accurate. I understand that if I mislead East Coast IV, LLC about my medical history it could cause serious injuries or death. I also understand there are alternative methods of rehydration, including oral fluids and oral multivitamins.

I affirm that at time of treatment by East Coast IV, LLC and staff, I am not under the influence of any recreational drugs or alcohol. Furthermore, I take responsibility for any consequences that result from misleading East Coast IV, LLC and staff regarding drug or alcohol use.

I understand that no medical procedure is without risk and that the risks of intravenous injection includes, but it not limited to, infection, bleeding, allergic reaction, pain, redness and death. By signing below, I acknowledge that I have been informed about its risks and consequences and accept responsibility for the clinical decisions that were made, along with the financial cost of treatment.

I acknowledge that East Coast IV, LLC does not participate in any health insurance plan but may elect to participate in HSA in the future. If using HSA as your form of payment, please not that if your insurance company declines to cover our services rendered, an invoice will be issues and the credit card on file will be charged.

I understand that I am ultimately responsible for the cost of all treatment, goods and services provided to the patient.

_____ _____

Name (Patient) Date of Birth

_____ _____

Patient Signature Date

EAST COAST IV

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portablity and Accountablity Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I understand that my personal information will not be shared with anyone without the express written consent of the patient. The only exception is if we are attempting to recoup payment from a third party payer.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand the organization is not required to agree to my request restrictions but If the organization does agree, then it is abound to abide by such restrictions.

I understand that I can revoke this consent in writing at any time, except to the extent that organization has taken action relying on this consent.

_____ _____

Name Date of Birth

_____ _____

Signature Date