BMore Hydrated, LLC

Patient Information

Date: _____

Name: _____ _____ _____
(Last) (First) (Middle)

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _____ Email: _____

DOB: _____ Age: _____ M or F: _____

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: _____

Do you have any **allergies** to medication: _____

Past surgeries: _____

Is it possible that you might be pregnant: _____ Are you currently breast feeding:_____

What are your present complaints: _____

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

Have you seen a physician for these conditions: _____ Physician's name: _____

How did you hear about our service? _____

BMore Hydrated, LLC

Name: _____ _____ _____
(Last) (First) (Middle)

Patient Confidential Medical History

If no medical problems, please initial here: [ ]

Heart and Circulatory System

____ High Blood Pressure
____ High Cholesterol
____ Heart Disease
____ Chest Pain
____ Murmur
____ Palpitations
____ Stroke
____ Anemia
____ Bleeding Disorder
____ Swelling/edema

Genitourinary System

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

Respiratory System

____ Asthma
____ Bronchitis
____ Pneumonia
____ Sinus Disease
____ COPD
____ Emphysema
____ Tuberculosis
____ Shortness of breath

Digestive System

____ Ulcer
____ Acid Reflux
____ Nausea
____ Vomiting
____ Constipation
____ Gall Bladder Disease

Neurologic System

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

Musculoskeletal System

____ Arthritis
____ Joint Problems
____ Bone Problems
____ Muscular Dystrophy

Other Illness

____ HIV/AIDS
____ Hepatitis
____ Diabetes
____ Cancer
____ Thyroid Disease

____ _____ (fill in other)

____ _____ (fill in other)

BMore Hydrated, LLC

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability 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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in print form upon request). I have reviewed and studied the notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of privacy practices from time to time, and that I may contact this organization at anytime at the address above to obtain a current copy of the notices of privacy practices. For questions and concerns, please contact our policy and compliance officer at (410)-864-2169.

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.

_____ _____

Patient's Name (print) Date of Birth

_____ _____

Signed (Patient or Legal Representative for Patient) Date

_____

Legal Representative's Relationship to Patient

BMore Hydrated, LLC

Contract for Services

I consent to BMore Hydrated, 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 have been provided access to the Notice of Privacy Practices of BMore Hydrated, LLC and understand that the patient's medical records may be used and disclosed for the purposes described in the Notice, including for payment and treatment activities.

I acknowledge that there are alternative methods of rehydration, including oral fluid rehydration and oral multivitamin therapy.

I affirm that at time of treatment by BMore Hydrated, 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 BMore Hydrated, LLC and staff, regarding my drug and alcohol use.

I understand that no medical procedure is without risk, and that the risks of intravenous injection includes, but is 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 BMore Hydrated, 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 note that if your insurance company declines to cover our services rendered, an invoice will be issued 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, and if payment form used is declined, an invoice will be issued and the credit card on file will be charged.

_____ _____

Patient's Name (print) Date of Birth

_____ _____

Signed (Patient or Legal Representative for Patient) Date

_____

Legal Representative's Relationship to Patient

BMore Hydrated, LLC

Medical Cannabis Questionnaire

MMCC ID# _____

Please indicate if you suffer from any of these medical conditions:

_____Severe condition where other traditional medical treatments have been ineffective

_____PTSD

_____Severe or chronic pain

_____Severe nausea

_____Glaucoma

_____Seizures or persistent muscle spasms

_____ Severe weight loss as a result of a medical condition

_____Severe loss of appetite as a result of a medical condition

_____Wasting syndrome

Please provide additional information regarding this/these conditions such as onset, duration, symptoms, treatments attempted, and physicians whom you have been treated by for this/these conditions.

_____

_____