

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 breastfeeding: _____

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 us? _____

BMore Hydrated, LLC

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

Patient Confidential Medical History

Heart and Circulatory System

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

Respiratory System

- ___ Asthma
- ___ Bronchitis
- ___ Pneumonia
- ___ Sinus Disease
- ___ COPD
- ___ Emphysema
- ___ Tuberculosis
- ___ Shortness of breath

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

Digestive System

- ___ Ulcer
- ___ Acid Reflux
- ___ Nausea
- ___ Vomiting
- ___ Constipation
- ___ Gall Bladder Disease

Musculoskeletal System

- ___ Arthritis
- ___ Joint Problems
- ___ Bone Problems
- ___ Muscular Dystrophy

Genitourinary System

- ___ Urinary Retention
- ___ Kidney Disease
- ___ Bladder Disease
- ___ Prostate Disease/BPH
- ___ Menstrual Problems

Other Illness

- ___ HIV/AIDS
- ___ Hepatitis
- ___ Diabetes
- ___ Cancer
- ___ Thyroid Disease

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.
- Obtained 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 bound to abide by such restrictions.

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

Name (Patient or Legal Representative for Patient)

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.

Name (Patient or Legal Representative for Patient)

Date of Birth

Signature (Patient or Legal Representative for Patient)

Date

Legal Representative’s Relationship to Patient