Date: _____

IV Intake form

Legal name: _____ D.O.B _____

Preferred name: _____ Age: _____ Sex: **F or M** (circle one)

Address: _____

City: _____ Prov: _____ Postal Code: _____

Tel (home): _____ Tel (alt): _____

Email: _____ Marriage status: _____

Personal Health Number: _____

Medical Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Health Information

Reasons for wanting IV therapy: _____

Height: _____ Weight: _____

List any known or suspected allergies: _____

_____

List any medical conditions: _____

_____

List any hospitalizations (surgeries/ emergency visits): _____

_____

List any other health related concerns: _____

_____

_____

List any prescription drugs you are presently taking: _____

_____

Have you had intravenous treatment before, if yes, what was your experience with it? _____

_____

Thank you for your time in filling out this form. Reverse side is for the doctor to fill out in your visit.

IV Therapy Intake Form

Medical disorders:

Kidney function: Recent testing_____ Results_____

Any urination problems:_____

Any lower back pain:_____

Urine strip: glucose:_____, protein:_____

Liver function: Recent Testing:_____ Results:_____

Any digestive problems:_____

Skin color_____

RUQ pain:_____

Heart function: Recent testing:_____ Results:_____

Blood pressure:_____ HR:_____ Rhythm_____

Skin color/temperature at feet/ ankles:_____

Posterior tibial and dorsal pedal pulses:_____

Hx of raynauds:_____

Blood disorder: Thalessemia:_____ G6PD:_____ Spherocytosis:_____

Sickle cell:_____ Clotting:_____

Neurological: Recent testing:_____Results:_____

Numbness or tingling:_____

Sensitivity to sharp/ dull on feet:_____

Blood sugar: Recent testing:_____ Results:_____

Any between meal symptoms?_____

RBS:_____ Time taken:_____ Last Meal:_____

I have filled out the preceding paperwork honestly and to the best of my knowledge. I have answered the questions honestly as presented on this page. I have reviewed the information on this page and agree that any information that I have given is reflected in the answers on this page as filled out by the practitioner conducting the interview. I understand that false answers may lead to complications in my treatment.

Patient Signature:_____

Cape IV Care

Consent for Intravenous (IV) Therapy

I, _____, hereby authorize Debbie Evans, FNP and her staff to treat me using intravenous therapy. I have shared with Debbie and staff of any known allergies that I may have. I understand that this treatment involves inserting a needle and injecting a standardized formula into my veins or muscles. I realize that there may be some discomfort at the sites of treatment and that it is my responsibility to inform Debbie or staff of any burning, pain, or negative reactions I may be experiencing. During intravenous treatment, it is possible for the injection fluid to leak out of the vein into the surrounding tissue. If I feel this is happening, it is my responsibility to notify staff immediately. I understand that although the infiltrated fluid may cause pain, it is not dangerous to my health and my body will reabsorb the fluid. I realize that during and after my treatment, I may experience minor discomfort at the site of treatment.

I am partaking in this treatment hoping that it will:

I understand that infusion therapy is considered experimental and there is no guarantee, stated or implied, that this will be a cure all to my condition. Debbie Evans FNP has explained to me that there may be unavoidable side effects, including, but not limited to:

1.Bruising where the IV was started. 2. Feeling tired or having diarrhea due to my body's reaction to the detoxifying process. 3. In an extreme case, if a blood clot forms and passes, it could cause respiratory complications during treatment.

I understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment. I understand that I am free to withdraw my consent and discontinue participation in these treatments at any time.

I understand that, except in emergencies, I must give at least 24 hours notice of my intent to cancel or reschedule my appointment.

_____ patient signature _____date

_____patient name PRINTED

Cape Integrative Care- Medical Weight Loss & Family Practice

Authorization to Release Medical Records

_____ _____ _____ _____

Printed Name | Patient's Social Security Number | Date of Birth | Today's Date

Address_____

Street Address | City | State | Zip Code | Phone

_____ _____

Signature of Patient or Patient's Representative | Relationship of Representative to Patient

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: _____

_____

_____

To: Cape Integrative Care- Medical Weight Loss & Family Practice

2441 Myra Drive Cape Girardeau, MO 63703

Phone: 573-803-0919 Fax: 573-818-2508

The information to be released includes:

Entire Medical Record_____ Other_____

The Medical Record Information will be used and/or disclosed for the following purposes:

At the request of the individual_____ Changing Primary Care Physician_____ Changing/seeing Specialist _____

Other (write purpose here)_____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please **exclude** the following information, if it is part of my Medical Record information *(Check any or all you want excluded from this authorization for use or disclosure):*

__ Chemical Dependency/Substance Abuse __ Psychiatric/psychological conditions __Sexually Transmitted Diseases

__Alcohol __ Drugs __ N/A

I understand that this Authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this Authorization at any time by notifying Cape Integrative Care- Medical Weight Loss & Family Practice in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Cape Integrative Care-Medical Weight Loss & Family Practice before receiving my revocation. I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

Cape Integrative Care- Medical Weight Loss & Family Practice

Financial Policy

Thank you for choosing Cape Integrative Care as your healthcare provider. We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. **Patients are responsible for understanding their health insurance coverage(s) and benefits**. There may be limitations and exclusions to coverage. **You are responsible for any charges not covered by your plan.**

Insurance Accounts: We ask that you present your insurance card at **every visit**. If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- If your insurance company requires you to pick a Primary Care Physician (PCP) one of our physicians must be the PCP listed on your insurance card.
- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information **within 30 days of the original date** of service a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. ***Self-pay patients are responsible for paying 100% of charges at the time services are rendered.***

Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **PRIOR** to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third party liability information **within 30 days of the date of service** may result in any unpaid balances transferring to patient responsibility. ***Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.***

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Financial Policy

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, Mastercard, American Express, and Discover. Cash or money orders are also acceptable methods of payment.

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail. Your failure to appear for a scheduled appointment or to cancel an appointment **at least 24 hours prior to the visit** may result in a missed appointment fee. This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Treatment of Minors: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date

(Revised 12/04/18)

Cape Integrative Care- Medical Weight Loss & Family Practice

HIPPA Notice of Privacy Practice

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPPA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for your convenience. The full Practice Privacy Policy and Assignment of Benefits Agreement is available here for you to read or you can ask for your own copy.

This Notice of Privacy Practice describes the ways we are allowed by law to use your protected information (medical records) or PHI to carry out treatment, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your provider will use your PHI as he/she has always done for treatment, payment, or other health care operations. In addition we may also disclose you PHI from time to time to other providers or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payment for our services. Front desk sign in sheets will be used where you will be asked to sign your name and we will call you by name in the waiting room when your provider is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us, including billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as in an emergency, your provider will try to obtain your consent as soon as possible. Your PHI may be disclosed to a public health agency or law enforcement as needed to protect you or others. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain federal law limitations. You may also ask us not to disclose your PHI for purposes of treatment, payment or health care operations, also that it not be disclosed to family members. This must be specific and in writing. However, you provider is not required to agree to such restrictions if he/she believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know whom we have revealed your information if it is other than for treatment, payment, or healthcare operations.

You have the right to a paper copy of this notice upon request. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing such a complaint.

By signing this form, you authorize all medical service sources and healthcare providers to use and/or disclose the PHI for treatment and care. In addition, you authorize the disclose of information regarding billing, condition, treatment, and prognosis to the following individuals, all of whom collaborate under Cape Integrative Care- Medical Weight Loss & Family Practice: Ashley Uchtman, Holistic Provider; Kendrick Morris, Healthcare Provider; Debbie Evans, Healthcare Provider; Laura Murphy, Healthcare Provider; Karen Graham, Healthcare Provider, Robert Bieser, Healthcare Provider; Susan Anglin, Facial Specialist

Individual(s) listed below are authorized to receive medical information:

_____

_____

_____

Signature_____ Date_____

(Revised 12/04/18)