NEW PATIENT FORM

PATIENT

Name ________________________ DOB ________________________

SSN ________________________ Gender ________________________

Address ____

____

Phone ________________________ ☐ Preferred Contact Method

Email ________________________ ☐ Preferred Contact Method

Employer ________________________ Occupation ________________________

CONTACT

Emergency Contact ________________________ Phone ________________________

Relationship ________________________ Alternate Phone ________________________

Primary Physician ________________________ Phone ________________________

Last Seen by Primary Physician ________________________ Reason ________________________

Referred By ____

Your Driver (if needed) ________________________ Phone ________________________

INSURANCE

Primary Insurance ________________ Member ID ________________ Group # ________________

Policy Holder ________________ DOB ________________ Relation to Patient ________________

Secondary Insurance ________________ Member ID ________________ Group # ________________

Policy Holder ________________ DOB ________________ Relation to Patient ________________

Medicare Number ____

I hereby authorize payment directly to Evolve Health for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my departments. I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature ____ Date: ________________________

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Evolve Health

PATIENT MEDICAL HISTORY

Name ______________________________ DOB ______________

- ☐ AIDS/HIV
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bipolar Disorder
- ☐ Blood clot/DVT
- ☐ Cancer
- ☐ Chemical Dependence
- ☐ Chest pain
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gastric Reflux
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Intestinal Disorder
- ☐ Kidney Disorder
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Neuropathy
- ☐ Pacemaker
- ☐ Psoriasis
- ☐ Schizophrenia
- ☐ Seizures / Epilepsy
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Other

____

____

____

Height ______________________

Weight ______________________

Current Chemotherapy ______________________

Smoking ______________________

Alcohol ______________________

Other Recreational Drugs ______________________

____

CURRENT MEDICATIONS

Name, Dose, Frequency

____

____

____

____

SURGERIES

____

____

____

DRUG ALLERGIES

____

____

____

____

Date of last TB test ______________________

Ever Test TB Positive? ______________________

FEMALES

____

Pregnant? ______________________

Date LMP ______________________

Last Mammogram Date

CONSENT

I certify this information is true and correct to the best of my knowledge.

____
Signature

____
Date

COMMENTS

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PATIENT CONSENT FORM

CONSENT TO INFUSION THERAPY, MEDICAL CARE AND TREATMENT

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to:

Please indicate intended treatment:

☐ Hydration/Supplement Therapy ☐ Weight Loss ☐ Infusion Therapy

☐ Diagnostic Laboratory Testing ☐ Ketamine IV Therapy ☐ Spravato™

☐ EMSELLA Therapy

and (Collectively the "Medical Therapies"), provided by Evolve Health (the "Infusion Center") and its associated physicians, providers, nurses, and clinicians (collectively, the Clinicians").

I hereby acknowledge that I understand that all the aforementioned "medical therapies" have possible risks/complications. Common complications associated with medical therapies consist of pain at site of injection, cutaneous irritation, redness /swelling, and muscle tenderness. Rare complications associated with all medical therapies include infection, allergic reactions, extravasation of fluid/medication (movement of fluid/medication outside the vein into the surrounding tissue), respiratory complications, cardiac complications, renal/urologic complications, and metabolic derangement. The risks and benefits of my indicated therapy have been explained to me, and I have been given an opportunity to have my questions answered to my satisfaction.

I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that the Infusion Center and the Clinicians will not be responsible for any injuries or damages that are the result of my noncompliance. Furthermore, I understand that if any employee or any individual associated with the Infusion Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

CONSENT TO TREATMENT IN AN OPEN TREATMENT AREA

I acknowledge and understand that Evolve Health provides infusion therapy and medical care in an open and in private treatment rooms. Despite safeguards and using reasonable care, it is always possible in Evolve Health's clinic that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, Evolve Health expects and requires that its patients maintain strict confidentiality with any information disclosed of others.

CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that Evolve Health may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to Evolve Health sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in Evolve Health's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Evolve Health personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in Evolve Health's Notice of Privacy Practices.

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Use and Disclosure of Information. In addition, I acknowledge and agree that Evolve Health may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I'm injured at work), state and federal government programs, Worker's Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services.

Request for Information from Others. I consent to Infusion Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Infusion Center's Notice of Privacy Practices, which provides information on how the Infusion Center may use or disclose my health information.

ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Infusion Center for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products (e.g. medications) provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered products and non-covered services also may include those products and services the Infusion Center and the Clinicians initially determine to be medically necessary but are later determined unnecessary or denied by my insurance or payer.

PERSONAL VALUABLES

I understand that the Infusion Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

Patient Name____ DOB __________________________

Address ____

____

X ____ Date __________________________
Signature of Patient or Legal Representative

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OFFICE AND FINANCIAL POLICIES

We dedicate ourselves to providing the best possible care and services to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our Care Team.

HEALTH INSURANCE

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with your insurance company and will only collect your co-pay, deductible, and/or co-insurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit. If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service.

PATIENT PAYMENTS

In the event your health plan determines a service "non-covered", you will be responsible for the complete charge. Payment is due upon each receipt of statement from this clinic unless prior arrangements have been made. I understand that there will be a $35.00 NSF fee for any returned checks.

REFERRALS

It is your responsibility to obtain a valid referral from your primary physician when required by your insurance provider.

MEDICATION HISTORY AUTHORITY

I grant Evolve Health the authority to download my medication history automatically from benefits manager (PBMs). This medication history may include prescriptions from all of my treating physicians within the last 12-month period.

I have read and understand the office policies, and I agree that such terms may be amended from time to time by the practice. I hereby assign my insurance benefits to be paid directly to Evolve Health.

X ____ Date: ________________________
Signature of Responsible Part

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