KARE INFUSION CENTER

Name_____ _____ _____
First Middle Last Date of Birth Age

SSN:_____-_____-_____ Marital Status: S M W D Gender: M F

Address:_____
Street City State Zip

Home Phone: (____) _____-_____ Work: (____) _____-_____ Cell: (____) _____-_____

I consent to be contacted by: (circle all that apply) Phone Text Email:_____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: _____

Drug Allergies:

What type of reaction?:

Current Medications:

Medical History:

Past Surgeries:

SIGNATURE: X_____ Date:_____

Patient Name: **DOB:** / /

PATIENT MEDICAL HISTORY

Place a check if you have:

__Aids/HIV
__Alzheimers
__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
__Others--please list:

Height:_____

Weight:_____

Circle Y for yes or N for no for the following questions:

Y / N Are you pregnant?
Y / N Currently under Chemotherapy?

Y / N Do you smoke cigarettes? If so, how much?
_____

Y / N Do you drink alcohol? If so, circle the amount:
rarely occasionally frequently

Y / N Do you use any illict drugs? If so, please list:
_____
_____
_____

Past Surgeries: please check all that apply

__appendectomy
__gall bladder removed
__heart surgery
__ hernia repair
__ hysterectomy
__tonsillectomy
__Other(s)—please list:

Current Medications: Please list name, dose and frequency:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

DRUG ALLERGIES:

1.
2.
3.
4.
5.
6.

When was your last TB skin test?

Have you ever tested positive for TB?

Have you ever had hepatitis?

Females:
Date of last menstrual period:

Date of last mammogram:

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give my permission to Kare Infusion Center to administer and perform such procedures as may be deemed necessary.

Print Patient Name:

_____

If patient a minor, print name of consenting adult:

_____

Signature of Adult:

_____

Date: _____

PATIENT CONSENT

1. 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 infusion therapy, medical examinations, and tests, provided by Kare Infusion Center and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). 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 non-compliance. 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.

2. CONSENT TO TREATMENT IN AN OPEN TREATMENT AREA

I acknowledge and understand that the Infusion Center provides infusion therapy and medical care in an open treatment environment. Despite safeguards and using reasonable care, it is always possible in the Infusion Center that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, the Infusion Center expects and requires that its patients maintain strict confidentiality any inadvertently disclosed health information of others.

3. CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD

I authorize the Infusion Center to photograph, videotape, or record me and agree that the images, video, or recordings may be used for medical reasons (including training, education, or research). I hereby release the Infusion Center, its employees, Clinicians, and other authorized persons from any responsibility which might arise from the taking and authorized use of such images, video, or recordings.

4. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that the Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center'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 Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices.

Use and Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center 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 am injured at work), state and federal government programs, Workers' 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. All of these uses and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

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.

5. **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.

6. **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.

7. **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.

8. **NO SHOW POLICY**

I understand that it is very important I give 24 hours notice to cancel my appointment. Failure to cancel in a timely manner will result in a $25.00 NO SHOW FEE.

9. **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: _____ Patient Date of Birth: _____
(Print)

Patient Address:

Street Address: _____

City: _____

Zip: _____

X_____ _____
Patient Signature or Legal Representative Signature Today's Date

If Signed by Legal Representative, Relationship to Patient
(e.g. parent, spouse, etc):

_____
(Print Name and Provide Relationship)

Patient Responsibility Agreement

Patient Name: _____ DOB: _____

INDIVIDUAL'S PATIENT RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.
- Co-payments are due at the time of service.
- If my plan requires a referral, one must be obtained prior to my visit.
- I understand that collected amounts are an **ESTIMATE** from information that my insurance provides Kare Infusion Center. In the event that my explanation of benefits determines a different charge I will be responsible for the full amount as stated on my EOB. In the event that Kare Infusion collects more than the EOB states a refund will be issued via check within 30 days of receiving the insurance payment.
- If additional balances are due after the treatment date according to my insurance EOB, I understand that I am financially responsible to pay the balance in full.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

Have there been any changes to your insurance coverage? YES NO

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to patient

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, representatives of Kare Infusion Center may call or mail my home or other alternative location, or leave a message on voicemail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointments, discussion of lab or procedure results, or to ask to call regarding an issue or concern.

I authorize Kare Infusion Center and staff to release laboratory results and reports to the following individuals listed below. At no time will a representative of Kare Infusion Center discuss your medical circumstances or condition without your consent.

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

This authorization shall be in force and effect for one year from the date of signature. I understand that I have the right to revoke this authorization, in writing, at anytime by sending such written notification to 6755 Phelan Blvd Ste 46, Beaumont, TX 77706.

_____ **NO, I do not wish my information to be released to anyone but myself.**

By signing this form I acknowledge that the notice of Privacy Practices was available and that I read (or had the opportunity to read if I choose) and understand the notice.

By signing this form, I am consenting to allow Kare Infusion Center and office staff to use and disclose my personal health information to carry out treatment, payment, and health care operations. I also accept full financial responsibilities for any services not covered by my insurance policy/policies.

_____
Patient Name

_____ _____
Signature of Responsible Party Date