Today's Date: _______/_______/______

PATIENT INFORMATION

Patient Name__ ____ **Gender:** ____________
First *M* *Last*

Address: ____ **Birth Date:** _____/_____/ ______
Street *City* *St* *Zip*

Social Security #: ______________________________ **Email address:** ______________________________

Home Telephone #: ( ) _______- __________ **Cell #:** ( ) ______-____________ **Work #:** ( ) ______-____________

If we need to contact you at home, may we leave a message? **Circle:** Yes No

Name of Employer ____

Employer address: ______________________________________ **Employer phone #**:__________________

In case of emergency, contact: Name _________________________ **Phone #**: ________________ **Relationship:** ___________

*By listing an emergency contact, you allow Infusion Associates PLLC to discuss your condition with the emergency contact.

Referring Physician: ______________________________ **Primary Care Physician:** ______________________________

Primary Insurance Subscriber Name: ____________________ **Secondary Insurance Subscriber Name**:____________________

Insurance Subscriber Date of Birth: ______________________ **Insurance Subscriber Date of Birth**: ______________________

***Name of individual financially responsible for acct:** ____________________________**DOB:** ____________________________

Patient Height:___________ **Patient Weight:**_______________

Medication Allergies and reaction if known: ____

____

If the patient is a minor, please complete the shaded information below:

Name of parent/legal guardian: ____

Address, if different from above: ____

Home phone #: ______________________________ Cell phone #:______________________________

HIPAA Release of Protected Health Information

Name	Relationship	Contact Information

- ❑ Please disclose my complete health information record. This may include but is not limited to – diagnoses, laboratory results, treatment, and billing records.
- ❑ I authorize the release of my protected health information with the exclusions listed below:

____
____
____
____

This release will expire 1 year after the date signed below, upon which a new form should be completed if a release is needed.

I may revoke this authorization at any time and can do so by submitting a written request to:

Compliance Officer – Infusion Associates

3310 Eagle Park Dr NE

Grand Rapids, MI 49525

I understand that my protected health information may have been shared with people and organizations before the date of revocation. I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditional upon whether I sign this authorization.

Print Patient's Name____Date_____________

Signature of Patient____

Name of legal guardian (print)____

Signature of legal guardian____

Patient Financial Agreement

1) ***Insurance:*** We accept assignment and participate with most insurance plans. Knowing your insurance benefits is your responsibility. If we do not participate with your insurance plan, we will bill your insurance as a courtesy, but you will be responsible for any amount not covered by your insurance. Please contact your insurance carrier with any questions about your benefits.

2) ***Patient Payment*:** All copayments and deductibles are to be paid at the time of service unless a payment plan has been agreed upon prior to your appointment. This arrangement is part of your contract with your insurance company. For your convenience, you may pay your statements through our web portal- www.PayMyDoctor.com. We accept VISA, MasterCard, Discover, and American Express.

   Any unpaid charges over 90 days old will be at risk of being submitted to a collection agency with additional collection agency fees. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process.

3) ***Registration:*** All patients must supply a copy of their current health insurance card(s) at each visit. If you fail to supply the correct insurance information, you may be financially responsible for the balance of the claim.

4) ***Claims:*** *We* will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

5) ***Uninsured Patients:*** We offer a discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed, and payment of the full charge will be expected before the next visit.

6) ***Copay Assistance:*** We will be happy to assist you in enrolling with available drug copay assistance programs. Copay assistance may not cover all out-of-pocket expenses after insurance payment. You will be responsible for any remaining balance after insurance and copay assistance payments are made.

7) ***Returned Checks:*** Will incur a $35.00 service charge

Information on foundation assistance can be obtained from the front desk staff upon request.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

Signature of patient/responsible party____Date ________________

Consent to Treatment and Medical Care

I hereby request services of Infusion Associates, PLLC and I consent to such treatment, medications, and procedures as ordered by my referring provider and my referring provider's associates to be provided by Infusion Associates, PLLC. I agree that Infusion Associates, PLLC is not liable for any act or omission when following my referring provider's instructions. I also understand that if I am in a condition to need hospitalization or special services during the course of my care which are not provided by Infusion Associates, PLLC, the services and hospitalization must be arranged by me, my legal guardian/representative, or my provider, and are my responsibility.

I will comply with all medically necessary procedures and treatments performed at Infusion Associates, PLLC. I have been given sufficient information to make an informed decision and consent to treatment. I am aware of the potential benefits, side effects and contraindications of the medication and therapy that my provider has ordered, and I have the right to refuse treatment at any time.

Authorization to Test and Release Information – I understand as a patient of this facility, I may be tested for the presence of HIV or an HIV antibody and Hepatitis viruses without my consent if any health care professional or other facility employee sustains percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids. This test is permitted by law and is for my protection as well as the protection of the physicians, providers, nurses, and other employees of Infusion Associates, PLLC.

Statement To Permit Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made to Infusion Associates PLLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Assignment of Benefits: I assign directly to Infusion Associates PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize IA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. I understand that there are many different types of coverage within a given insurance company. Therefore, I may receive a bill for any non-covered benefits.

Agreement to Pay: Infusion Associates PLLC has agreed to supply me with any supplies and services ordered on behalf of me. I agree that I am responsible for payment for all such supplies and services provided. Balances released to an attorney or collection agency for non-payment may incur additional fees, which will also be the responsibility of the patient or responsible party. I am responsible for paying co-pay/co-insurance at the time of service. If I do not have insurance coverage, I understand that I am solely responsible for any and all services rendered. I understand the services must be paid for in full upon receipt of the statement unless other arrangements are made with the billing office. If my account balance becomes overdue and is placed with a collection or legal agency, I agree to pay all attorney or collection agency fees associated with my delinquent account.

Release of Information: I authorize Infusion Associates PLLC to release any and all medical information contained within my medical records to referring providers, hospitals, laboratories, therapists, pain clinics, or a specifically named location in the course of my treatment under a physician or nurse practitioner at Infusion Associates, PLLC. This information may include my physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS, ARC, and/or psychological information. I give the authorization to Infusion Associates, PLLC to obtain any of my medical records, mailed or faxed, pertinent to my medical condition. This authorization is in effect until I revoke it.

Notice of Privacy Practices: I acknowledge I have been offered the Infusion Associates PLLC notice of privacy practices. I may request a copy at any time.

Patient Signature____Date__________

ResponsiblePartySignature____Date__________

Relationship to Patient____