Infectious Disease-Internal Medicine-IV Infusion

Intravenous (IV) Infusion Therapy Intake Form

Patient Information

Name: _____Date: _____
Address: _____City: _____ State: _____ ZIP Code: _____
Phone: (H) _____ (C) _____Date of Birth: (/ /) Age: _____Sex: M / F Occupation: _____Email: _____ In case of emergency, please contact: Name: _____ Phone: _____ How did you hear about us? Internet___ Face book___ Walk-in ___

What are your main complaints? (Please check all that apply)

- Fatigue
- low energy
- Stress
- Poor diet due to busy lifestyle
- Brain fog or trouble concentrating
- Low mood or depression
- Headaches or migraines
- Weight gain or difficulty losing weight
- Slow metabolism
- Asthma and Allergies
- Recent surgical procedure
- Recent illness □ Cold or flu symptoms
- Facial wrinkles or fine lines
- Dull or dry skin
- Malabsorption Issues
- Other _____

Which statements best describe why you are here today? (Please check all that apply)

- I want to have more energy and feel better overall
- I want to do everything I can to nourish my body
- I want to do everything I can to enhance my weight loss efforts •
I want to prevent getting sick
- I want to recover quickly from my surgery or illness
- I want to slow the aging process

- I want to feel and look younger
- I want to have smoother, brighter and more vibrant skin
- I want to cleanse my body of toxins
- I want to recover quickly from a hangover

MEDICAL HISTORY

Are you pregnant or breastfeeding? Yes / No
Date of last chemistry screen or another lab testing _____ Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Please check all that apply)

- Hypermagnesemia (High magnesium levels)
- Hypercalcemia (High calcium levels)
- Hypokalemia (Low potassium levels)
- Hemochromatosis (High iron levels)
- Other _____
- Are you a diabetic? Yes / No
- Are you a smoker? Yes / No

If Yes, how much do you smoke? _____

- How many alcoholic drinks do you consume in a week? _____ •

Do you use any recreational drugs? Yes / No
If Yes, which ones and how often? _____

Prescription Medications

Strength Frequency Condition being treated
_____
_____
_____

Over the Counter Drugs

Strength Frequency Condition being treated
_____
_____
_____

Vitamins and Other Supplements

Strength Frequency Condition being treated
_____
_____
_____

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No
Do you take any diuretics or water pills? Yes / No
If Yes, please list: _____
Do you take any steroids, i.e. Prednisone? Yes / No
If Yes, please list: _____
Do you have any medication or food allergies? Yes / No
If Yes, please list: _____

Do you have any of the following conditions? (Please check all that apply)

- Blood pressure problems (High or low)
- Heart Problems
- Stroke or "mini-stroke"
- Kidney Problems
- Kidney Stones
- Asthma
- Optic Nerve Atrophy or Leber's Disease
- Sickle Cell Anemia
- G6PD Deficiency
- Sarcoidosis
- Parathyroid problems (High levels) List any other medical conditions you have (not mentioned above):

_____
_____
_____

List of all surgical procedures you've had with approximate dates:

_____

Is there anything else you'd like the nurse and physician to know?

_____

Checklist

- Your completed Intravenous (IV) Infusion Therapy Intake Form
- A list of all prescription medications, OTC medications, vitamins/supplements that you take
- A copy of your most recent bloodwork is helpful
- Your signed Consent Form
- Your signed HIPPA Notice
- Make sure you are well hydrated prior to your visit. We suggest drinking 1-2 16oz. bottles of water. Dehydration can make it difficult to insert an IV. • Make sure you eat something prior to your visit. We suggest a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, light-headed or dizzy.

During your first visit for IV Vitamin Therapy infusions

During the first visit, a NP will discuss your main complaints and desired outcomes with you. The NP will review your medical & surgical history and any medications you are taking. Based on this assessment, your Intravenous (IV) infusion will be customized to address your individual needs. If you have any complex medical conditions, the physician at MedFusion may request you obtain blood work or further testing prior to administering any IV infusions.

What to expect

The IVs used during you Intravenous (IV) infusion therapy are the same that you would find in a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful setting and leave you feeling calm, relaxed, and refreshed. Depending on your customized IV cocktail, the infusion can be finished in as little as 25-45 minutes. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized, and refreshed.

Thank you for choosing MedFusion

Intravenous (IV) Infusion Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the physician at MedFusion. (Initials)_____ I have informed the NP and/or physician of any known allergies to medications or other substances and of all current medications and supplements. (Initials)_____ I have fully informed the NP and/or physician of my medical history. (Initials)_____

Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease.

These IV infusions are not a substitute for your physician's medical care. (Initials)_____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. If you experience an adverse reaction at any point after receiving your infusion call the office during business hours, if it is outside regular business hours or if you feel it is an emergency situation call 911 and seek emergency care. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

(Initials)_____

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution. (Initials)_____
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes. (Initials)_____
3. Risks of intravenous therapy include but not limited to:

a) Occasionally: Discomfort, bruising and pain at the site of injection.

(Initials)_____

b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. (Initials)_____

c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

4. Benefits of intravenous therapy include:

a) Injectables are not affected by stomach, or intestinal absorption problems. (Initials)_____

b) Total amount of infusion is available to the tissues. (Initials)_____ c) Nutrients are forced into cells by means of a high concentration gradient. (Initials)_____

d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation. (Initials)_____

I am aware that other unforeseeable complications could occur. I do not expect the NP(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the NP(s) and/or Physician(s) to exercise judgment during treatment with regards to my procedure. (Initials)_____

I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered. (Initials)_____

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. (Initials)_____

My signature on this form affirms that I have given my consent to IV Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree to the all statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by my NP and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy. 5. I release MedFusion, PC and all the staff from all liabilities **Medical** or **Legal** for any complications or damages associated with my Intravenous (IV) Infusion Therapy.
6. In the event anything goes wrong I will not slander or tarnish MedFusion or anyone associated, otherwise legal actions will be taken against me.

Patient's Name: _____ Date of Birth: _____

Patient's Signature and Date: _____

NP or Physician's Name: _____

NP or Physician's Signature and Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES (Effective August 1, 2017)

At MedFusion Faisal Wasi, MD and his medical staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protecting your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:
Make sure that health information that identifies you is kept private Give you this Notice of our legal duties and privacy practices with respect to health information about you

Follow the terms of the Notice that is currently in effect how we may use and disclose health information about you:

- For Treatment
- For Payment
- For Healthcare operations
- For appointment reminders
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation •
  Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

For any services provided by MedFusion, Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to Amend
- Right to Accounting of Disclosures
- Right to Request Restrictions

Right to Request Confidential Communication of Your Medical Records: The original copy of your and/or electronic medical record is the property of MedFusion and Faisal Wasi, MD. You may request a copy of your records to be transferred by completing a medical records release form. As allowed by Oklahoma state law, there will be a fee for providing you with this service. We require 14 business days from the date of

your request to prepare and send your records unless the records are for urgent of life-threatening health issues. Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint. For complete, detailed information regarding privacy laws, visit: **www.cms.gov/hipaa**.

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MedFusion 421 Stonewood Dr, Broken Arrow OK 74012 - Phone: 918-872-8822

Website**: www.medfusionok.com**

Permission to Share your Health Information

We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please inform us.

Acknowledgement of Receipt of the MedFusion HIPAA NOTICE OF PRIVACY PRACTICES:

We request that you sign this form acknowledging you have received, read, and reviewed the MedFusion HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient. I will notify Faisal Wasi, MD and/or his staff of any changes or updates to this record. This acknowledgement will become part of your records.

Printed Name of Patient: _____

Signature of Patient & Date _____