PATIENT INFORMATION

First Name: ______________________ Last Name: ____________________ M.I.________ Sex: ________

Social Security: ____________________ Date of Birth: ____________________ Age: _______ Height: _______

Weight: __________ Marital Status: ________________ Race: __________________ Language: ________________

Address: ____

City: _________________________ State: ____________________ Zip Code: ______________________

Home #: ________________ Cell #: _________________________ Email: ___________________________

Emergency Contact: ____ Phone: _______________________

Relationship: __________________ Address: ____

INSURANCE INFORMATION

Primary Insurance Plan: _____________________ ID: ____________________ Group #________________

Policy Holders Last Name: ______________________ First Name: _____________________ DOB: __________

Social Security: ____ Phone#: ___________________________

Secondary Insurance Plan: ___________________ ID: _________________ Group#_____________________

Policy Holders Name: ______________________ First Name: _____________________ DOB: ____________

Social Security: ____ Phone #: ____________________________

PHARMACY INFORMATION

Pharmacy Name: ____

Phone Number: _________________________________ Fax Number: ________________________________

Address or Major Cross Street: ____

Patient (or Parent/Guardian) Signature: ____ Date: _____________

LifeCare
INFUSION

PATIENT HISTORY

Patient Name: ____ DOB: ______________________

Have you had any surgeries Yes____ No_____ Example: Gallbladder, Appendix, Hysterectomy, Vasectomy, Plastic Surgery, Tonsillitis, Heart Surgery: ____ Date: ____________

Are you pregnant? Yes_____ No _____ If yes, due date? ________________

Do you Smoke? Yes____ No_____ if yes, how often? ___________________

Do you Drink? Yes ____ No ______ if yes, how often? ___________________

Past Medical History	Yourself	Family Members	Relationship
Diabetes	Yes___ No___	Yes___ No___	____________
High Blood Pressure	Yes___ No___	Yes___ No___	____________
Asthma	Yes___ No___	Yes___ No___	____________
Heart Disease	Yes___ No___	Yes___ No___	____________
Abdominal pain	Yes___ No___	Yes___ No___	____________
Anxiety	Yes___ No___	Yes___ No___	____________
Chest Pain	Yes___ No___	Yes___ No___	____________
Headache/Migraine	Yes___ No___	Yes___ No___	____________
Osteoporosis	Yes___ No___	Yes___ No___	____________
Pneumonia	Yes___ No___	Yes___ No___	____________
Conjunctivitis	Yes___ No___	Yes___ No___	____________
Bronchitis	Yes___ No___	Yes___ No___	____________
Lung Disease	Yes___ No___	Yes___ No___	____________
Cholesterol	Yes___ No___	Yes___ No___	____________
Arthritis	Yes___ No___	Yes___ No___	____________
Hepatitis	Yes___ No___	Yes___ No___	____________

If other please explain:____

Do you take any medication that may affect your sexual health? ***YES/NO***
Have you ever been tested for HIV/AIDS? ***YES/NO***
Have you ever been diagnosed with a sexually transmitted infection (STI)? ***YES/NO***
Have you ever been exposed to Syphilis, Gonorrhea, Chlamydia, HIV or Hepatitis C through social activities, blood transfusions or needle usage in the recent past? ***YES/NO***
Do you have a rash on the palms of your hands or legs that has been present for longer than a month? ***YES/NO***
Sagebrush Health Services provides FREE STI/HIV testing, treatment, and prevention services. Are you interested in receiving more information or counseling regarding these services? ***YES/NO***
SBH and Lifecare Infusion CTR will continue to monitor your risk of infection, should you at any time feel you need further information or have any questions you can reach us at **(888)404-6564**.

Patient Signature: ____ Date: ____________________

LifeCare
INFUSION

MEDICATION PROFILE

Patient: ______________________________ Date: ____________

Medication/Food allergies: ☐ No allergies ☐ Allergic to: (list item and reaction)

____

____

Would patient like to speak to a pharmacist? ☐ Yes ☐ No

Please list all current prescriptions, over the counter, and herbal therapies. If patient receiving more than 10 medications, use a second page:

Date Prescribed or started*	Name of Medication	Dose	Route	Frequency	Date Stopped	Reason For Use

**If patient unsure when medication started, use date therapy started with LifeCare*

6415 S. Fort Apache rd
Suite 175
Las Vegas, NV. 89148
Office: (702) 665-5730
Fax: (702) 780-4887

Medical Records Release Form

Date: ______________________

Patient Last Name:______________________________ First_________________________ MI_____

DOB: ______________ Male____ Female ____ Last 4 of SSN: __ __ __ __

Address: ____

City: ________________ State________________ Zip Code _________

I, ____ am giving you permission to release any medical

(please print)

Records needed to **LifeCare Infusion CTR** for any of my billing needs from them. This includes Dr's orders, clinical notes, insurance information, patient demographics information on record.

Please fax to **LifeCare Infusion CTR**

Thank you,

X ________________________________
Signature

X ________________________________
Relationship to Patient (If Applicable)

FINANCIAL AND RESPONSIBILITY POLICY

Patient Information: All patients must complete our patient registration form prior to their initial office visit with the doctor. It is the patient's (and/or responsible party's) responsibility to keep this office informed of any changes in information (i.e. change of address, phone number, change of insurance, etc.) You will be required to update this information on an annual basis. **Initial:**____________

Payment Information: payment is due at the time of the service. For your convenience we accept cash, Visa, and Master card credit and debit cards. Any co-pays you have with your insurance are you responsibility. They are dues and payable at time of the service. **Initial:**____________

Insurance: As a courtesy to our patients, we will bill your insurance. In order to do so, we must have updated and accurate insurance information. Please be aware that your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits. Your account with this office is your responsibility whether or not your insurance company pays. If your insurance company has not paid your account in full within 60 days, your account will become a "CASH" account with the balance due and payable immediately and prior to your next visit. **Initial:**____________

Usual and Customary Rates: Our practice is committed to providing the highest standard of health care for our patients. We make every effort to align our fees with what is considered to be usual and customary for our area of specialty.

Initial:____________

Collection Policy: I agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account. If referred to collection service, I understand I will be discharged as a patient. I understand that id my bills are left unpaid for 90 days, it will be automatically sent to collections.

Initial:____________

Returned Checks: There will be a $25.00 fee for all returned checks. If a check is returned, you will be expected to pay by cash or credit card for all the subsequent services.

Missed Appointments: Because our practice is extremely busy, please help us better serve you by keeping all scheduled appointments.

NO CALL NO SHOW POLICY

A NO show fee of $50 will be charged if an appointment is not canceled within 48 hours of the scheduled appointment time.

Initial:____________

All Infusion treatment have been prescribed to me per my doctors' orders I have read, understand and agree to the financial policy.

Patient Name: ____________________________ Date: ____________

Patient Signature: ____________________________

Infusion Completed by: ____________________________

Printed Name: ____________________________ Date: ____________

LIFECARE INFUSION ORIENTATION FORM

My signature below this form attests that I have received, read, and / or been instructed, in detail, on the following information.

_______My rights as a customer.

_______My responsibility as a customer.

_______How to voice a complaint or concern.

______My work order denoting medication and supplies.

_______My Release of Information / Assignment of benefits.

_______The safe and proper use of medication and supplies

_______Medication and Supply

_______Functional Assessment, Mental Assessment

_______Patient Needs

_______Important Life Care Pharmacy telephone numbers, including after-hours information.

_______Information on Life Care Infusion products and services.

_______Received information regarding Advance Directives and Resuscitation.

_______Medicare Supplier Standards.

_______Community Resources.

_______HIPPAA Privacy Notice

TOLL FREE NUMBER: 888-201-8884

Patient / Beneficiary:	Nurse:
Signature:	Signature:

Lifecare Infusion Center
PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name: ____ ID________________________________

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to Lifecare Infusion Center for pharmaceuticals and services that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named facility, any and all information which will assist in processing my claims for pharmaceuticals and services that I am receiving from the above named facility even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named facility any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals and services that I have received, rather than directly to the above named facility, I agree to endorse those checks and send them immediately to the above named facility.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Lifecare Infusion Center financial hardship program.

_______ **(Initials) I acknowledge that I have been advised of my financial responsibility to Lifecare Infusion Center.**

I hereby agree that Lifecare Infusion Center or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the pharmaceuticals and products provided. I have received the products ordered. I have received a copy of a patient handout that contains: Patient Bill Of Rights and Responsibilities, HIPAA Privacy Notice, Emergency Planning, Home Safety, Infection Control, Making Decisions about Your Health Care, How to Access Medications In Case of an Emergency or Disaster, How to Handle Adverse Reactions and Grievance / Complaint Reporting.

I have received monograph/instructions for medications received. I have received facility marketing material and information on the facility's scope of services. I have received instructions on how to follow up with Lifecare Infusion Center

I understand that prescribed pharmaceuticals cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (702) 697-2105 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this facility by calling Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at 919-785-1214 and/or the Nevada Department of Health and Human Services at (702) 486-6515.

Identified needs/problems: The patient may be unfamiliar with use of the pharmaceuticals and services provided. Expected outcomes: The patient will be provided the pharmaceuticals and services to comply with the physician's prescription. The patient will use the pharmaceuticals and products as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X________________________________ DATE:____/____/______

PATIENT OR RESPONSIBLE PARTY

PRINT NAME: ____

IF BENEFICIARY IS UNABLE TO SIGN:____

WITNESS SIGNATURE / RELATIONSHIP:____

REASON PATIENT UNABLE TO SIGN:____

Please return the Patient Authorization and Plan of Service Form to Lifecare Infusion Center. Thank you for choosing Lifecare Infusion Center.

Form Revised: 12/08/2020