LifeCare
INFUSION CENTER

INTAKE PACKET

Lifecare Infusion CTR

Patient Information

First Name | **Last Name** | **M.I.**

Social Security | **Date of Birth** | **Age** | **Sex** ☐ Male ☐ Female

Weight | **Height** | **Marital Status** ☐ Single ☐ Married ☐ Divorced | **Race** | **Language**

Address

City | **State** | **Zip Code**

Home # | **Cell #** | **Email**

Emergency Contact | **Phone** | **Relationship**

Address

Insurance Information

Primary Insurance

Insurance Plan | **ID** | **Group #**

Policy Holder Last Name | **First Name** | **DOB**

Social Security | **Phone #**

Secondary Insurance

Insurance Plan | **ID** | **Group #**

Policy Holder Last Name | **First Name** | **DOB**

Social Security | **Phone #**

Pharmacy Information

Pharmacy Name

Phone Number | **Fax Number**

Address or Major Cross Street

X_____ Date: _____

Patient (or Parent/Guardian) Signature

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PATIENT HISTORY

Patient Name **DOB**

Have you had any surgeries? ☐ Yes ☐ No Example: Gallbladder, Appendix, Hysterectomy, Vasectomy, Plastic Surgery, Tonsillitis, Heart Surgery

Procedure / 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

Condition	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 have 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. If you need further information or have any questions, please call (888) 404-6564.

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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 receives more than 10 medications, use a second page.

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

**If patients are unsure when medication starts, use date therapy started with Lifecare.*

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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, including 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 service. For your convenience we accept cash, Visa, and MasterCard credit and debit cards. Any co-pays you have with your insurance are your responsibility and are payable at the time of service. **Initial:** _____

Insurance: As a courtesy to our patients, we will bill your insurance. 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 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 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 as 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 if my bills are left unpaid for 90 days, they 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 with credit card for all subsequent services. **Initial:** _____

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 has been prescribed to me by my doctors' orders. I have read, understand, and agree with the financial policy.

_____
Patient Name

X_____ Date: _____
Patient (or Parent/Guardian) Signature

_____
Infusion Completed by (Print Name)

X_____ Date: _____
Infusion Completed by (Signature)

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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 from Lifecare Infusion CTR for any of my billing needs from them. This includes doctor's orders, clinical notes, insurance information, and patient demographics information on record.
Please fax **Lifecare Infusion CTR.**

Thank you,

X_____ **X**_____
Signature *Relationship to Patient (If Applicable)*

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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.

1. My rights as a customer.
2. My responsibility as a customer.
3. How to voice a complaint or concern.
4. My work order denoting medication and supplies.
5. My Release of Information / Assignment of benefits.
6. The safe and proper use of medication and supplies.
7. Medication and Supply.
8. Functional Assessment, Mental Assessment.
9. Patient Needs.
10. Important Lifecare Pharmacy telephone numbers, including after-hours information.
11. Information on Lifecare Infusion products and services.
12. Received information regarding Advance Directives and Resuscitation.
13. Medicare Supplier Standards.
14. Community Resources.
15. HIPAA Privacy Notice.

TOLL FREE NUMBER: 888-201-8884

Patient / Beneficiary:	**Nurse:**
Signature:	**Signature:**

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PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name **ID**

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I must 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 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 authorize 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 understood the information above. I have been instructed on and understanding 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 monographs / instructions for medications received. I have received facility marketing materials 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 make 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 formal grievance in writing and forwarding it to the Governing Body. You can expect a written response within 14 working days of 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 Name

X_____ Date: _____

Patient (or Parent/Guardian) Signature

X_____ Date: _____

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.

From Revised: 04/01/2026