Wellness Infusion Group
HIPAA Consent

I have been given the opportunity to review a copy of the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and permit Wellness Infusion Group to disclose my personal health information (PHI) to the following:

___ Myself Only ___ Spouse ___ Parents ___Siblings
___Adult Children ___Personal Representative ___Employer
Print name(s) of above: _____
_____
_____
__

Other: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship to patient:

Relationship: _____

Witnessed by: _____

Wellness Infusion Group
Release from Liability Waiver

This waiver indicates the patient understands that the protocols offered, while showing promise, may or may not have widespread acceptance by the medical community. As with any protocol, response may vary from one patient to the next.

The patient assumes all responsibility and releases providers from any liability associated with protocols. The patient agrees that the risk may vary from minor to great, up to and including death. The patient takes full responsibility for researching all treatments before undergoing them and agrees not to hold Wellness Infusion Group or any associated providers responsible.

I understand that the FDA does not necessarily approve of these treatments. I authorize Wellness Infusion Group providers and/or nurses to administer IV protocols or other services as my health condition requires and as we discuss and agree on over time on a case by case basis. I understand that there may be times I will be required to have lab work done related to the treatments I am receiving.

In signing this document below, you agree and understand all of the above statements.

Patient Name	Patient Signature	Date

Wellness Infusion Group
Intravenous (IV) Infusion Therapy Consent Form

This document is intended to serve as informed consent for your intravenous (IV) infusions therapy as ordered by the medical provider at Wellness Infusion Group (WIG).

(Initials) ____ I have informed the medical provider at Wellness Infusion Group of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse 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 email care.

(Initials) ____ I understand that I have the right to be informed of the procedures, any feasible alternative options, and the risks and benefits. 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.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but are not limited to:
    (a) Occasionally: Discomfort, bruising and pain at the site of injections.
    (b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    (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.
    (b) The total amount of infusions is available to the tissues.
    (c) Nutrients are forced into cells by means of a high concentration gradient.
    (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 nurse(s) and/or physician(s) to anticipate and/or explain all risk and possible complications. I rely on Wellness Infusion Group providers to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of 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. 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 all statements made above.
2. Intravenous (IV) infusion therapy has been adequately explained to me by the Wellness Infusion Group provider.
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 Wellness Infusion Group, and all the medical staff from all liabilities for any complications or damages associated with my intravenous (IV) infusion therapy.

Patient's name and date of birth: Please print:

_____

Patient's signature and date:

_____

Wellness Infusion Group provider name: Please print, sign and date:

_____

Wellness Infusion Group - 1101 N. Jim Day Rd - Salem, IN 47167
Phone: 812-596-2211

Wellness Infusion Group
Insurance Information for Billing

Last name: _____ First: _____ M.I.: ___
DOB: _____ Phone number: _____
Emergency Contact: _____ Phone: _____
Married: __ Single: ___ Spouse's Name: _____
Spouse's Phone Number: _____

Primary Insurance Information

Insured Name: _____ DOB: _____
Insurance Company: _____
Member ID: _____
Group Number: _____
Patient's relationship to insured: _____

Secondary Insurance Information

Insured Name: _____ DOB: _____
Insurance Company: _____
Member ID: _____
Group Number: _____
Patient's relationship to insured: _____

Payment Policies

___ You are financially responsible for anything your insurance doesn't cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your responsibility is determined by your insurance company and policy you have chosen. Your claim will be processed according to the benefits of your

insurance plan. The deductible, co-insurance, and co-pay are your financial responsibility. It is your responsibility to know and understand your insurance plan, your deductible, and your co-insurance.

____ You are responsible to call the office and pay your copay for telehealth visits if it applies. Copays are applied to telehealth visits the same as office visits.

____ We do accept checks. A service charge of $25.00 is added for all returned checks.

____ We will charge $25.00 for no call/no show appointments. This is not covered by your insurance company. If you have Medicaid you will be financially responsible for this amount.

____ We will charge $25.00 for all repeat urine drug screens. Repeat screens will be required if the tab is pulled on the cup or if there is evidence that the test has been tampered with in any way. Dr. Kinzey, Janna Johnson, or Tracie Davis will determine the need for a repeat urine drug screen.

Prescription Policy

Please do not wait until your last pill to call for a refill. There is a 72-hour turn around for prescription refills. Please sign and date this document showing that you have read and understand our policies.

Signature: _____ Date: _____

Wellness Infusions Group
Patient Intake Form

Name: _____ DOB: _____ Today's Date: _____
Address: _____City:_____ State: ____ Zip: _____
Phone Number: _____ Cell ___ Home ___
Primary Care Physician: _____ Phone: _____
Allergies? Y/N List: _____ Reaction: _____
Emergency Contact/Phone: _____
Email: _____
May we update and communicate with you through email? Y/N Initial ___
May we communicate with you by text? Y/N Initial ___
May we leave a message with medical information? Y/N initial ____
Male: _____ Female: _____ Are you pregnant? ___ Last period? _____
How did you hear about us? ___internet ___friend ___doctor ___other
List other/friend/doctor: _____
We are a specialty clinic providing IV infusions, blood draws, weight loss and other injections, and other treatments. We do not provide primary care services. What is the reason for your visit: _____
_____
List prescribed medications: _____
_____
Supplements: _____
_____
Pharmacy: _____ Phone Number: _____
Review of systems (Circle all that apply): **Respiratory**: sore throat, earache, sinus drainage, sinus pressure, wheezing, asthma, cough: Dry or Productive **Cardio**: shortness of breath, chest pain, chest pressure, poor arterial circulation, swelling to lower extremities _____
GU/GI: pain with urination, frequency, blood in urine, discharge, abdominal pain, nausea, vomiting, diarrhea _____
Skeletal: joint pain, difficulty lifting or bending arms/legs _____
Neuro: brain fog, unfocused, headaches, vision changes, memory loss, depression, anxiety, Alzheimer's, Dementia _____
Eyes: red, irritated, itching, blurry vision, other _____

Pain: Y/N Rate: _____(1-10) Where: _____ How long: _____ **Skin**: Rash/Skin issues: _____
Endocrine: Temperature intolerance: Y/N hot or cold: _____
Low sex drive: Y/N **Hormone Replacement**: _____
Blood clots: Y/N **Anticoagulant**: Y/N Type: _____
Chemotherapy: Y/N Type: _____
Medical Conditions: (Circle all that apply):
Asthma/Bronchitis/COPD/Allergies/High Blood Pressure/Diabetes/Heart Disease/Stent/AtrialFibrillation/CHF/HeartAttack/Ulcers/Gastritis/Reflux/IBS/Crohns/ulcerative Colitis/Stroke/Sleep Apnea/Kidney Stones/Blood in Urine/Frequent Urinary Tract Infections/HIV/Hepatitis/Liver Disease/Jaundice/Thyroid Problems/Bleeding Clots/Anxiety/Nervous Disorders/Depression/MS/Other List:
_____
Surgical History: Y/N List: _____
_____
OB & Pregnancy History (females): Total Pregnancies ___ Full Term ___ Pre Term ___ Miscarriages ___ Living ___ Age Onset of Menses ___ Age at Menopause ___
Family History:
Mother: Alive/Deceased Health conditions: _____
_____
Father: Alive/Deceased Health conditions: _____
_____
Other: _____ Alive/Deceased Health conditions: _____
_____
Social History: **Work**: Employed/Unemployed/Retired/Disabled
Relationship Status: Single/Married/Separated/Divorced/Widowed
Tobacco Use: Y/N How much? _____
Alcohol Use: Y/N How much? _____
History of Substance Abuse: Y/N List: _____
Have you ever passed out or had any reaction to giving blood or getting an IV? Y/N (If yes, please explain what happened) _____
Do you consent to telehealth or telephone visits? Y/N Prefer: _____
Height: _____ Weight: _____

Patient Name: _____
Signature: _____ **Date**: _____