

Paragon Infusion Centers Patient Information

Please complete the following form as accurately as you are able. Inaccurate and/or incomplete information can delay our ability to authorize your treatments, obtain referrals, and file your insurance claims for payment resulting in possible delays in your treatment.

	PATIENT INFO	RMATION		
Last Name:	First Name:			
DOB:	☐ Male ☐ Fema	le	SSN:	
Phone Number:		Alternate Phon	ne Number:	
Address:				
Email:				
Emergency Contact:		Emerge	ncy Contact Phone:	
Ethnicity:	Race:			
☐ Hispanic or Latino	☐ American Indian / A	laska Native	☐ White	
☐ Not Hispanic or Latino	Asian		Other Race	
☐ Decline to specify	☐ Black or African Am ☐ Hawaiian or Other P		☐ Decline to specify	
	_			
What Physician sent you to our infusio				
Primary Care Physician:		Phone:	Fax:	
Address:				
	PRIMARY INSURANC	E INFORMAT	ION	
Insurance Name:			Phone:	
Policy ID#:		Group	o #:	
Is the policy holder the same as the pa	tient? Yes No			
If No, Policy Holder:				
SSN:		Relation to pat	cient:	
	SECONDARY INSURAN	ICE INFORMA	ATION	
Insurance Name:			Phone:	
Policy ID#:		Group	p #:	
Is the policy holder the same as the pa	tient? Yes No			
If No, Policy Holder:			DOB:	
SSN:		Relation to pat	ient:	
	TERTIARY INSURANC	E INFORMAT	TON	
Insurance Name:			Phone:	
Policy ID#:		Group	p #:	
Is the policy holder the same as the pa	tient? Yes No			
If No, Policy Holder:			DOB:	
SSN:		Relation to pat	tient:	



Paragon Infusion Centers Patient Financial Agreement

Dear Patient.

This letter agreement sets forth our company's financial payment policy. I, the undersigned, understand and acknowledge that as a recipient of medical care at or by Innovative Infusions, LLC (a Paragon Healthcare, Inc. subsidiary) ("II" or "we") I am responsible for all charges regardless of my circumstances for reimbursement. I understand that a fee is charged for all medical services including, but not limited to, visits, treatments, infusion or injection services, examinations and/or medical reports. I acknowledge and agree that I have the primary duty and obligation to pay PHI for such medical services, notwithstanding, any contract I may have with any third party payer (e.g., Insurance company, employer, etc.).

As a courtesy, we will attempt to verify your insurance coverage, if any, and <u>estimate</u> the amount you may owe for services provided (e.g. co-pay, deductible, co-insurance, etc.) should insurance apply. However, some or all of the services provided may not be covered by your insurance, and you are responsible for any and all fees not covered or only partially covered by insurance. It is your sole responsibility to timely provide us with accurate and current insurance information. Your insurance is a contract between you and your insurance company. It is your responsibility to know and understand the level of service covered by your insurance.

I, the undersigned, hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes II and all parties it deems necessary to submit claims to obtain benefits and reimbursement for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to II all benefits. I understand I am ultimately financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account in accordance with my insurance company's assignment. Any unpaid charges are my responsibility.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances. Should I fail to pay unpaid charges for more than 30 days, I authorize unpaid charges to be charged to the credit card provided and on file (if any). Unpaid charges over 60 days will incur a monthly service fee of at least \$25.00. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill. I understand and agree that some additional charges may come through from my treatments that are not included in the initial estimated bill. There is a \$25.00 service charge for each and every returned check.

I give my consent to II to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

Patient Name (Print)

Date



Signature

CONSENT for COMMUNICATION via E-MAIL and TEXT MESSAGE

(Provider - Patient)

haraby consent to baye the staff of
hereby consent to have the staff of Paragon Healthcare, Inc. and any of its subsidiaries ("Paragon"), which may include pharmacists, eimbursement and billing staff and nurse practitioners involved in my care communicate with me and my physicians, where appropriate, via e-mailing or text messaging regarding the following aspects of my nedical care and treatment: test results, prescriptions, appointments, billing, etc. I understand that e-mail nd/or text message is not a confidential method of communication and may have the following risks:
 Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients. Senders can easily misaddress an email or text and send the information to an undesired recipient. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted
 his or her copy. Your employers and/or on-line services may have a right to inspect emails and texts sent through
 their systems. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection or errors can occur in the transmission. Emails and texts can be used as evidence in court. Emails and texts may not be a reliable means of communication. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.
further understand that there is a risk that e-mail or text message communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse tractitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail or text message communications between my physician and me or members of his office staff, or between my physician and other physicians, urse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or no to the Emergency Room and not rely on e-mail or text message. I agree not to disclose sensitive medical information such as information relating to HIV, mental health or substance abuse. I understand not acknowledge that Paragon cannot guarantee the privacy, security or confidentiality of information ransmitted via email or text. I understand that I may revoke my consent at any time by advising Paragon in writing.
mail Address:
Cell Phone Number for Text Messages:

Date



Paragon Infusion Centers Patient Consent For Treatment

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 infusion medication and infusion therapy that my physician has ordered. I understand that I have the right to refuse the recommended therapy at any time. I acknowledge that I have read and fully understand this consent, related documents, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature. No guarantees or promises have been made to me regarding the outcome of the treatment. I also authorize the company to photograph, video and/or use any other mediums which result in the permanent documentation of my image for safety, medical, scientific or educational purposes. I agree that any such photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the company so long as the manner of disposition shall be permanent destruction.

HEPATITIS B VIRUS CONSENT FOR TREATMENT

For patients on the following medications: Actemra, Cimzia, Inflectra, Orencia, Ocrevus, Renflexis, Remicade, Rituxan, Simponi Aria: If I have not had a Hepatitis B Virus (HBV) vaccination or I refuse such vaccination, I understand that due to my exposure to potentially infectious material, I may be at risk of acquiring HBV. I understand that by not obtaining this vaccine, I continue to be at an increased risk of acquiring HBV. a serious disease.

or acquiring rib v, a scribas ais			
	PREGNANCY AND BREASTFEE	DING CONSENT FOR TR	EATMENT
	nd have no reason to suspect that I a gnant during treatment including mis		he potential risks, known and unknown, mity. If I should become pregnant, I will
 I am pregnant, will conti or congenital deformity. 	nue treatment and am aware of the po	otential risks, known and un	known, to the fetus including miscarriage
	vill continue breastfeeding while rece d while receiving treatment.	ving treatment. I am aware	of the potential risks, known and unknown
	PATIENT PRIVA	CY NOTIFICATION	
be used and disclosed by my purpose of providing health car I understand that other patient acknowledge that the infusion	hysician, office staff, and others outs e services. Although all NPs, RNs and i s or staff in the infusion center may o center is an open treatment area that	ide of these offices who are nfusion center staff will atte verhear the staff when med may be monitored by video	that my protected health information mae involved in my care and treatment for the mpt to conceal written medical information ical information is provided to me. I furthe surveillance. By signing this page I give may have read and fully understand the above
	EMPLOYE	E INCIDENT	
	stick injury or exposure to blood/bod ed to, Hepatitis B, Hepatitis C, and HIV		e your labs drawn by our clinical staff which
	RELEASE OF PAT	ENT INFORMATION	
	fusion center medical director, office oviding medical care to leave messag		this office who are involved in my care and iscuss medical information with the
Name	Relationship	Name	Dolationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Patient or Responsible Party Sign	gnature		Date

Innovative Infusions, LLC is a wholly owned subsidiary of Paragon Healthcare, Inc.

Relationship to Patient



Patient's Current Medications List

Patient Name:			OOB:	Today's Date:	
Medication Name	St	rength and Freque	ncy	Comme	nts
Allergies				Physicians and Specia	lties
		-			
		-			
		-			
		-			



Paragon Infusion Centers Peripheral IV Consent & Waiver

Should you choose for your IV to remain in place following your discharge from the clinic in order to avoid having another IV stick on your next treatment, this infusion center and/or clinic will NOT take any responsibility for the IV or any potential complications that could possibly occur with your IV. You will be deemed to have chosen to keep your IV in place should you leave our facility with your peripheral IV in place.

We will wrap your IV for your protection.

- Do not use the IV to inject ANY substance.
- Do not remove the bandage.
- Keep the dressing clean and dry.

A Nurse will assess the IV at the next visit and only use the IV if it functions properly (e.g. flushed without pain or resistance) and there is no sign of inflammation, redness or tenderness. Please be aware that at our sole and absolute discretion another IV catheter may have to be placed.

We reserve the right, at our sole and absolute discretion, not to use the existing IV if the site appears to have been tampered.

If you go home with your IV, but decide not to have another treatment, you may return to us for removal of the IV or you may elect to remove it yourself.

Removal instruction:

- 1. Wash hands
- 2. Remove dressing
- 3. Apply clean gauze over the insertion site and push down while sliding out the catheter.
- 4. Keep pressure for 3 minutes
- 5. Remove gauze and apply a band-aide if necessary

Please watch for redness, swelling and pain around the insertion site. These could be signs of infection. Please contact the clinic if you have any concerns.

I have read and understand the information stated herein re my peripheral IV.

I understand that the infusion center and/or clinic will not be responsible for any potential complications.

Patient or Responsible Party Signature	Date	
Relationship to Patient		

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Paragon Infusion Centers Cancellation & "No Show" Fee Policy

Paragon Infusion Centers are committed to providing exceptional care. Recognizing that everyone's time is valuable, we ask that you provide advanced notice if you are unable to keep your appointment.

Please call us by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations.

To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Paragon Infusion Centers reserves the right to charge a fee of \$35.00 for each missed (No Show) appointment and/or for any appointment that is not canceled with advanced notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in any 12 month period may result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Signature		Date	
Patient Name (Print)			