



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 INFORMATION

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Male Female SSN: _____
Phone Number: _____ Alternate Phone Number: _____
Address: _____
Email: _____ Preferred Language: _____
Emergency Contact: _____ Emergency Contact Phone: _____
Ethnicity: Race:
 Hispanic or Latino American Indian / Alaska Native White
 Not Hispanic or Latino Asian Other Race
 Decline to specify Black or African American Decline to specify
 Hawaiian or Other Pacific Islander
What Physician sent you to our infusion center: _____
Primary Care Physician: _____ Phone: _____ Fax: _____
Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____
Policy ID#: _____ Group #: _____
Is the policy holder the same as the patient? Yes No
If No, Policy Holder: _____ DOB: _____
SSN: _____ Relation to patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____
Policy ID#: _____ Group #: _____
Is the policy holder the same as the patient? Yes No
If No, Policy Holder: _____ DOB: _____
SSN: _____ Relation to patient: _____

TERTIARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____
Policy ID#: _____ Group #: _____
Is the policy holder the same as the patient? Yes No
If No, Policy Holder: _____ DOB: _____
SSN: _____ Relation to patient: _____



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) ("I" 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 **estimate** 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 I 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 I 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 I to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I acknowledge that I understand and agree to the terms outlined above:

Patient Signature

Date

Patient Name (Print)



CONSENT for COMMUNICATION via E-MAIL and TEXT MESSAGE (Provider - Patient)

I, _____, hereby consent to have the staff of Paragon Healthcare, Inc. and any of its subsidiaries ("Paragon"), which may include pharmacists, reimbursement 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 medical care and treatment: test results, prescriptions, appointments, billing, etc. I understand that e-mail and/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.

I 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 practitioners 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, nurse 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 go 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 and acknowledge that Paragon cannot guarantee the privacy, security or confidentiality of information transmitted via email or text. I understand that I may revoke my consent at any time by advising Paragon in writing.

Email Address: _____

Cell Phone Number for Text Messages: _____

Signature

Date



REMICADE (infliximab) Consent and Disclosure

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TO THE PATIENT (AND OTHERS LEGALLY RESPONSIBLE FOR THE PATIENT): You have the right as a patient, to be informed about your condition and how Infusion therapy medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment. I voluntarily request that Innovative Infusions, LLC, (dba Paragon Infusion Centers) "Paragon" and other affiliated health care personnel as they may deem necessary, treat my condition (or the condition of the person for whom I am responsible). I understand that the treatment is planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize to be treated.

I understand that no warranty or guarantee has been made regarding the results of treatment. I realize that there may be risks and hazards in treating this present health condition, with or without conventional medicine, and there may also be risks and hazards related to the planned treatment; including worsening of present symptoms, development of new symptoms, possible undesirable interactions between various treatments. Serious infusion reactions have been reported with REMICADE, including hives, difficulty breathing, and low blood pressure. Reactions have occurred during or after infusions. In clinical studies, some people experienced the following common side effects: respiratory infections (that may include sinus infections and sore throat), coughing, and stomach pain or mild reactions to infusion such as rash or itchy skin. The reports of serious infections, including tuberculosis (TB) and Reports of lymphoma (a type of cancer) in patients on REMICADE and other TNF blockers are rare but occur more often than in the general population. Some of these infections have been fatal. Nervous system disorders have also been reported.

I have been given an opportunity to ask questions about the treatment of this health condition using conventional methods with my ordering provider. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment with my ordering provider, and I believe that I have sufficient information to give this informed consent.

I certify that I have read this form (or have asked to have it read to me), and that I understand its contents. I also certify that neither Paragon nor any affiliated staff have made guarantees to me as to the success of this treatment.

Patient or Responsible Party Signature

Date

Relationship to Patient

Patient Name (Print)

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



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)