



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: _____			<input type="checkbox"/> Male <input type="checkbox"/> Female		SSN: _____			
Phone Number: _____			Alternate Phone Number: _____					
Address: _____								
Email: _____						Preferred Language: _____		
Emergency Contact: _____						Emergency Contact Phone: _____		
Ethnicity:			Race:					
<input type="checkbox"/> Hispanic or Latino			<input type="checkbox"/> American Indian / Alaska Native			<input type="checkbox"/> White		
<input type="checkbox"/> Not Hispanic or Latino			<input type="checkbox"/> Asian			<input type="checkbox"/> Other Race		
<input type="checkbox"/> Decline to specify			<input type="checkbox"/> Black or African American			<input type="checkbox"/> Decline to specify		
			<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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



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.

PREGNANCY AND BREASTFEEDING CONSENT FOR TREATMENT

For females: Please check one (1) of the following:

- ☐ I am not pregnant now and have no reason to suspect that I am pregnant. I am aware of the potential risks, known and unknown, the fetus if I become pregnant during treatment including miscarriage or congenital deformity. If I should become pregnant, I will notify the clinical staff immediately.
- ☐ I am pregnant, will continue treatment and am aware of the potential risks, known and unknown, to the fetus including miscarriage or congenital deformity.
- ☐ I am breastfeeding and will continue breastfeeding while receiving treatment. I am aware of the potential risks, known and unknown to my breastfeeding child while receiving treatment.

PATIENT PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside of these offices who are involved in my care and treatment for the purpose of providing health care services. Although all NPs, RNs and infusion center staff will attempt to conceal written medical information, I understand that other patients or staff in the infusion center may overhear the staff when medical information is provided to me. I further acknowledge that the infusion center is an open treatment area that may be monitored by video surveillance. By signing this page I give my consent to be monitored and recorded by video. By signing this page, I acknowledge that I have read and fully understand the above statement.

EMPLOYEE INCIDENT

In case of an employee needle stick injury or exposure to blood/body fluids, you consent to have your labs drawn by our clinical staff which would include, but not be limited to, Hepatitis B, Hepatitis C, and HIV.

RELEASE OF PATIENT INFORMATION

I, authorize my physician, the infusion center medical director, office staff and others outside of this office who are involved in my care and treatment for the purpose of providing medical care to leave messages and/or voicemails and discuss medical information with the following persons:

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Patient or Responsible Party Signature

Date

Relationship to Patient

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Patient's Current Medications List

Patient Name: _____ DOB: _____ Today's Date: _____

Medication Name	Strength and Frequency	Comments

Allergies

Physicians and Specialties



VIVITROL (Naltrexone) Injection Consent

Page 1 of 3

What is VIVITROL?

VIVITROL is an injectable medicine for the treatment of alcohol dependence in adults 18 years and older. To benefit from VIVITROL, you need to stop drinking before starting the medicine. To be effective, treatment with VIVITROL must be used along with other alcohol dependence recovery measures, such as counseling. VIVITROL may not work for everyone. VIVITROL has not been studied in children under the age of 18.

What important information should I know about VIVITROL?

VIVITROL may be associated with liver damage or hepatitis.

VIVITROL blocks the effects of opioid-containing medicines.

- You may not feel the same effect of opioid-containing medicines including medicines for pain, cough and diarrhea.
- You may not feel the same effects if you use or abuse heroin and other illegal (street) opioids.
- DO NOT take large amounts of opioid medicines to overcome the VIVITROL block. This can lead to serious injury, coma, or death.

VIVITROL has been associated with severe allergic pneumonia.

- Call your doctor if you develop shortness of breath, coughing, or wheezing.

Who should not take VIVITROL?

DO NOT take VIVITROL if you:

- Are taking or have a physical dependence on opioid containing medicines.
- Use or have physical dependence on opioid street drugs.
- Are allergic to VIVITROL. The active ingredient is naltrexone. For a complete list of ingredients in Vivitrol, see the Patient Information Pamphlet

What should I tell my doctor before starting VIVITROL?

Tell your doctor about all of your medical conditions, including if you:

- Have liver problems
- Use opioid containing medicines
- Use or abuse street (illegal) drugs
- Have hemophilia or other bleeding problems
- Have kidney problems
- Are pregnant or plan to become pregnant. It is not known if VIVITROL can harm your unborn baby.
- Are breastfeeding. It is not known if VIVITROL passes into your milk, and if it can harm your baby.

Tell your doctor about all the medications you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Especially tell your doctor if you take any opioid containing medicines for pain, cough or diarrhea.

****Carry written information to alert medical personnel that you are taking VIVITROL so that they can treat you properly in an emergency.**



VIVITROL (Naltrexone) Injection Consent

Page 2 of 3

How do I take VIVITROL?

VIVITROL is given as an intramuscular injection in your buttocks. It is injected by your doctor or healthcare provider about once a month. Because VIVITROL is an injection, once it is given, you cannot remove it from the body.

If you miss an appointment for a VIVITROL injection, schedule another appointment as soon as possible.

Whenever you need medical treatment, be sure to tell the treating doctor or nurse that you are receiving VIVITROL injections.

What should I avoid while taking VIVITROL?

VIVITROL may make you feel dizzy. Do not drive a car, work with machinery, or do other dangerous activities until you and your doctor know how VIVITROL may affect you.

What are the possible side effects?

VIVITROL may cause side effects including:

- Headache
- Fatigue
- Dizziness
- Vomiting
- Decreased appetite
- Painful joints
- Muscle cramps

A reaction at the injection site. The reaction could be pain, tenderness, swelling, redness, bruising, and /or itching. Sometimes reactions at the site can quickly worsen and skin and other tissue can be permanently damaged and require surgery. If you have an injection site reaction tell your doctor or healthcare provider immediately.

FDA WARNING

FDA is alerting healthcare professionals about the risk of serious reactions at the injection site among patients treated with Vivitrol (naltrexone). Vivitrol is administered intramuscularly to treat alcohol dependence. FDA has received nearly 200 reports of injection site reactions, including cellulitis, induration, hematoma, abscess, sterile abscess and necrosis. Some patients needed surgical intervention. The risk may be increased if the drug is injected subcutaneously or accidentally into fatty tissue.

Practitioners using Vivitrol should use only the specially designed needle that comes with the drug, and take care not to inject the material intravenously, subcutaneously, or into fatty tissue. The special needle may not be long enough to reach muscle tissue in patients with significant gluteal fat. Healthcare providers should consider alternative treatment in these cases.

Patients who develop pain, swelling, bruising, itching or redness that does not improve within two weeks should be instructed to report this, and should be referred to a surgeon.

Additional Information:

FDA MedWatch Safety Alert. Vivitrol (naltrexone). August 12, 2008.

<http://www.fda.gov/medwatch/safety/2008/safety08.htm#naltrexone>



VIVITROL (Naltrexone) Injection Consent

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Patient acknowledge any risk by reading and signing this consent and guidelines for VIVITROL.

I do hereby acknowledge that I have read and understand the information provided to me, including the FDA Guidelines on VIVITROL provided on the previous page(s). I accept and understand the risk to myself, including possible anaphylaxis and other post-injection reactions. I also agree to abide in total compliance to the guidelines for VIVITROL and understand that any non-compliance to these guidelines may result in significant health risk for me and possible removal from future injections or transfer from the Infusion Center.

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

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



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)