Statement of Patient Rights

* The right to efficient and equal service regardless of race, sex, physical or mental handicap, religion, ethnic background, education, social class or economic status.

* The right of considerate, courteous and respectful care from all our staff.

* The right of complete information in terms the average patient can reasonably be expected to understand.

* The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. The right to discuss alternatives to proposed procedures.

* The right to obtain assistance in language interpretation.

* The right to know the names, titles, and professions of the staff to whom you speak and from whom you receive services or information.

* The right to refuse examination, discussion and procedures to the extent permitted by law, and to be informed of the health and legal consequences of this refusal.

* The right of access to your personal health records.

* The right of respect for your privacy.

* The right of confidentiality of your personal health records as provided by law.

* The right to expect reasonable continuity of care within the scope of services and staffing of the facility.

* The right to respect for your rights and religious options.

* The right to present complaints to the Director of our facility without fear of reprisal.

PATIENT DATA SHEET

First: MI: Last:

Date of Birth: Age: Gender: Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

_____

Phone Numbers:	OK To Call	Best Time To Call
_____	☐	_____
_____	☐	_____
_____	☐	_____

May we send you text messages for your appointment reminders to the number(s) listed above?

☐ Yes ☐ No

May we send you text messages for marketing materials, including patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred Language: _____ Interpreter Required? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ Part-Time ☐ None ☐ Retired ☐ Self-Employed

PATIENT EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

SPOUSE EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

MEDICAL HISTORY FORM

Patient Name:	Today's Date:	
Referring Physician:	Date of Birth:	Age:
Primary Care Physician:	Are you presently working?	
Date of Next Physician Appointment:	Date of Injury or Onset:	

Reason for Therapy:

Have you been hospitalized for the present condition? ☐ Yes ☐ No If Yes, date:

Did you have surgery for this condition? ☐ Yes ☐ No If Yes, date:
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐ Yes ☐ No
If yes, please describe:

Have you ever received therapy in the past for the condition mentioned above?
Describe previous treatment:

Previous treatment: ☐ Successful ☐ Unsuccessful

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Do you smoke or use tobacco? ☐ Yes ☐ No
Do you wear glasses or contacts? ☐ Yes ☐ No	Height (inches):_____Weight (lbs):_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ Allergies ☐ Latex ☐ Other	☐ Diabetes ☐ Type 1 ☐ Type 2	☐ Kidney Problems
☐ Anemia	☐ Dizziness	☐ Metal Implants
☐ Anxiety or Panic Disorders	☐ Epilepsy or Seizure Disorder	☐ MRSA
☐ Arthritis ☐ OA ☐ RA	☐ Fainting	☐ Multiple Sclerosis
☐ Asthma	☐ Fatigue or Weakness	☐ Nausea / Vomiting
☐ Bleeding Disorder	☐ Fever or Chills	☐ Osteoporosis
☐ Blood Pressure ☐ High ☐ Low	☐ Fractures	☐ Pacemaker
☐ Blood Thinners	☐ Headaches	☐ Parkinson's Disease
☐ Bowel or Bladder Disorder	☐ Head Injury or Concussion	☐ Peripheral Vascular Disease
☐ Cancer	☐ Hearing Impairment	☐ Respiratory or Breathing Problems
☐ Congestive Heart Failure	☐ Heart Disease or Heart Attack	☐ Ringing in Ears
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Sexual Dysfunction
☐ Cough ☐ Chronic ☐ New	☐ Hernia	☐ Skin Abnormalities
☐ Currently Pregnant	☐ HIV or AIDS	☐ Stroke or TIA
☐ Deep Vein Thrombosis (DVT)	☐ Hypersensitivity to Hot or Cold	☐ Thyroid Problems
☐ Depression	☐ Hypoglycemia	☐ Tuberculosis

List any other medical problems and explain:

MEDICAL HISTORY FORM

Name of Medication	Dosage	Frequency	Route
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other
4.			☐ Injection ☐ Oral ☐ Topical ☐ Other
5.			☐ Injection ☐ Oral ☐ Topical ☐ Other
6.			☐ Injection ☐ Oral ☐ Topical ☐ Other
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other

Over the Counter Medications (check all that apply):

☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet

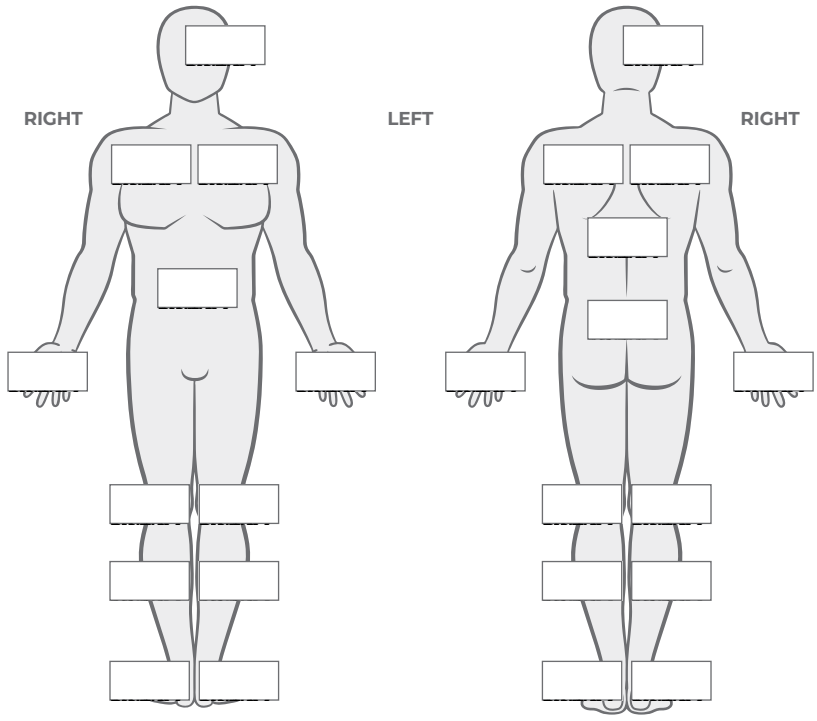
Pills

☐ Vitamins/Herbal Supplements ☐ Other:

☐ RIGHT HANDED
☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
– – – –	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CLICK ON THE CIRCLE OF YOUR CURRENT PAIN LEVEL

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Have you recently traveled outside of the United States? ☐ Yes ☐ No If Yes, date returned to U.S.: If Yes, list the country(ies) visited:	
Signature of Patient:	
Printed Name of Patient:	Date:
Signature of Therapist:	Date:

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: **A/C#:** **Name:** **A/C Type:** **Office #:**

CONSENT TO TREATMENT
I consent to Infusion treatment
Initials:

TREATMENT OF MINORS
I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
Initials: _____

LIABILITY
I know and agree that: **Hy-Vee Health** is not responsible for loss or damage to personal valuables.
Initials: _____

WAIVER AND RELEASE
I hereby release, discharge and acquit: **Hy-Vee Health,** its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, emergency medical technician, physician or urgent care services.
Initials: _____

AUTHORIZATION OF PAYMENT
I hereby assign all benefits directly to: **Hy-Vee Health** I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment, and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice of Privacy Practices.
Initials: _____

FINANCIAL POLICY
I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS
I acknowledge receipt of Notice of Privacy Practices.
Initials: _____
I acknowledge receipt of the Statement of Patient Rights.
Initials: _____

NOTICE OF PUBLIC WIFI
I understand I am receiving access to Hy-Vee Health Public wifi for the purposes of my own use only.
Initials: _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ **Witness Signature:** _____ **Date** _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend – Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens – Open Houses
- ☐ Marketing Ad – Print
- ☐ Marketing Ad – TV
- ☐ Marketing Ad – Billboard
- ☐ Marketing Ad – Direct Mail / Email
- ☐ Marketing Ad – Facebook
- ☐ Marketing Ad – Other _____

Specify if other: _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Signature **Date**