AMERICAN
INFUSION CARE
SPECIALTY INFUSION

PATIENT CONSENT FORM

PATIENT INFORMATION

Patient Name:_____ DOB:____/____/_____

Age:_____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Pregnant?: ☐ Yes ☐ No SS #: ____-___-_____ Drivers License: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: (_____) - _____ - _____ Email: _____

Emergency Contact Name: _____

Relationship: _____ Cell Phone #: (_____) - _____ - _____.

Primary Insurance:

Insurance Name: _____ Name on card: _____

Start Date : ____/____/_____ Relationship to cardholder: ☐ Parent ☐ Spouse ☐ Self

ID #: _____ Group #: _____

Secondary Insurance: (You may skip this section if you can provide your Insurance ID)

Insurance Name: _____ Name on card: _____

Start Date : ____/____/_____ Relationship to cardholder: ☐ Parent ☐ Spouse ☐ Self

ID #: _____ Group #: _____

Consent for Information Release and Billing Authorization. I hereby grant permission to American Infusion Care to disclose any information related to the care I have received at their facility to my insurance company and its representatives. Additionally, I authorize and request my insurance company to make direct payments to American Infusion Care for the services provided. I acknowledge my responsibility for any charges not covered, co-payments and coinsurance.

_____ ____/____/_____

Patient/Guardian (Name/Signature) Date

AMERICAN INFUSION CARE
SPECIALTY INFUSION

TERMS OF SERVICE

Patient Name:_____ DOB:____/____/_____

Please initial and sign:

_____ I grant American Infusion Care permission to contact me exclusively through the contact I have provided.

Cell Phone #: (_____) -_____-_____ Email: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

_____ I authorize American Infusion Care to access my pharmaceutical records and history.

_____ I authorize American Infusion Care to send my medical records, via mail, fax, or email, to another physician or medical facility while I am receiving infusion treatment. _____ I grant American Infusion Care permission to forward any specimens collected during my infusion treatment to an external laboratory. These laboratory services are distinct from those provided by American Infusion Care and will be invoiced separately by the external laboratory. American Infusion Care will make every attempt to send the specimen to a laboratory within the insurance network, but it is my responsibility to notify American Infusion Care of a laboratory that is covered by my insurance.

_____ I acknowledge that it is my duty to inform American Infusion Care promptly of any updates to my personal information, such as changes in mailing address, phone number, insurance policies, or any other details essential for contacting me, processing payments, or facilitating my infusion treatment. I confirm that all the information provided today is both accurate and current.

_____ ____/____/_____

Patient/Guardian (Name/Signature) Date

AMERICAN INFUSION CARE
SPECIALTY INFUSION

FINANCIAL POLICY

Patient Name:_____ DOB:____/____/_____

Kindly be aware that settling your bill is an integral aspect of your infusion process. Below is a summary of our financial policy, which you must review and endorse before commencing your infusion treatment.

1. At check-in, it is imperative to furnish your up-to-date insurance cards and a valid photo ID for scanning into our system. The patient assumes complete responsibility for the appointment and any potential insurance billing issues that may occur from outdated insurance details.
2. For insured patients, co-payments and co-insurance payments are to be settled upon check-in.
3. Any outstanding balance from a prior visit must be cleared before scheduling any subsequent appointments.
4. Accounts with a 90-day past due balance will be automatically referred to a collection agency unless prior arrangements have been agreed upon.
5. Your scheduled appointment includes a 15-minute grace period. Should you arrive beyond this timeframe, rescheduling may be necessary.
6. Please be aware that waiving deductibles and co-payments is unlawful and constitutes a breach of contract with the insurance companies.
7. A $25.00 fee may be applied to any patient who misses their appointment without providing at least 24 hours advance notice for collection.

Insurance Coverage

8. I, the undesigned, accept the responsibility of obtaining a referral as required by my insurance company. I commit to having the necessary referral and presenting it at my infusion appointment; failure to do so may result in appointment rescheduling.
9. Furthermore, I hereby grant authorization for my insurance carrier(s) to make direct payments to American Infusion Care for any eligible insurance benefits in lieu of payments to me, for services provided. I am aware of my financial responsibility for any charges not covered by my insurance carrier(s), including copays and deductibles.
10. I also provide consent to American Infusion Care to share my medical records with my insurance carrier(s) as needed.
11. I have carefully read and fully comprehend the Financial Policy and Insurance Coverage detailed above, and I hereby agree to abide by all of its provisions.

_____ ____/____/_____

Patient/Guardian (Name/Signature) Date

AMERICAN INFUSION CARE
SPECIALTY INFUSION

FINANCIAL POLICY

Patient Name:_____ DOB:____/____/_____

This notice explains the ways in which your information may be utilized and shared, as well as how you can access this information. Please read it carefully. Thank you!

At American Infusion Clinic, we are dedicated to handling your protected health information responsibility. This notice on Health Information Practices outlines the personal information we gather, as well as the circumstances in which we utilize or share this information. It also outlines your rights regarding your protected health information. This notice is currently in effect and pertains to all protected health information as defined by federal regulations. **For more information or to report a complaint**

If you have any inquiries or require further information, please don't hesitate to contact our office directly at (832)-800-3213. In the event you believe your privacy rights have been violated, you have the option to file a complaint with our office by speaking to the office manager or with the Office for Civil Rights, U.S. Department of Health and Human Services. Rest assured, there will be no retaliation for filing a complaint with either the office manager or the Office for Civil Rights. You can reach the Office for Civil Rights at the following address: 200 Independence Ave S.W., Room 509F, HHH Building, Washington, D.C. 20201.

Acknowledgment of Receipt of Privacy Notice

Upon my request, I will receive a copy of American Infusion Care Notice of Privacy Policies, which outlines the permissible uses and disclosures of any information under federal and state law. I have read and understood the contents of this Notice. I hereby request the following restriction(s) regarding the utilization of my personal medical information. I have carefully read the HIPAA Notice of Privacy Practices as described above, and I fully understand and agree to all of its provisions.

Please allow access to Protected Health Information (PHI) to my:

☐ **Parent/Guardian** ☐ **Spouse/Child** ☐ **Other:**_____

Patient Name:_____ DOB:____/____/_____

_____ ____/____/_____

Patient/Guardian (Name/Signature) Date

AMERICAN INFUSION CARE
SPECIALTY INFUSION

RELEASE OF INFORMATION

Patient Name:_____ DOB:____/____/_____ Date of

Service : ____/____/_____

Release of Information and Authorization for Billing Health Plans. I grant American Infusion Care permission to disclose any information related to the care I have received at their facility to my insurance company and its representatives. Additionally, I authorize and request my insurance company to make direct payments to American Infusion Care for the services provided. I acknowledge my responsibility for all charges not covered, including co-payments and coinsurance.

_____ ____/____/_____

Patient/Guardian (Name/Signature) Date

AMERICAN INFUSION CARE
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PROOF OF SERVICE

Patient Name:_____ DOB:____/____/_____

This is to certify that the above patient has been under the professional care on the following date:

Date of Service : ____/____/_____ Service Location: _____

_____ ____/____/_____

Patient/Guardian (Name/Signature) Date