HILL COUNTRY
Infusions

NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Date: _____

Age: _____ Male ❑ Female ❑ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Drivers License #: _____ Employer: _____

Occupation: _____ Work Phone: (_____)_____

Email Address: _____

BILLING CONTACT

Name: _____ Relationship to Patient: _____

Address: _____Phone: (_____)_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

HOW DID YOU HEAR ABOUT US?

❑ Doctor: _____ ❑ Insurance

❑ Friend ❑ Internet /Website

❑ Ad (*which publication?):* _____ ❑ Radio

PREVIOUS IF INFUSIONS?

Have you had any previous IV vitamin infusions? ❑ Yes ❑ No

If Yes, did you have any side effects from the infusion? _____

_____

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ACKNOWLEDGEMENTS/CONSENTS *(please initial on the line next to each section after reading)*

_____ **Receipt of Notice of *Privacy Practices***

I, *(print patient or guardian name)*_____, have read a copy of Hill Country Infusion's *Notice of Privacy Practices.* (This document is available at our front desk).

_____ **Cancellation Policy**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Hill Country Infusions reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment within 24 hours.

_____ **Release of Medical Information**

I **do / do not** *(circle one)* authorize Hill Country Infusions and its designated representatives to release medical information to my spouse, parent, or guardian.

_____ **Contact Permission**

If Hill Country Infusions needs to contact you (patient) regarding an appointment, medication, or any other reason, it is permissible to *(check all that apply)*:

- ❑ Leave a message on an answering machine.
- ❑ Speak with spouse / significant other. (Name:_____)
- ❑ Speak with other family members.

_____ **Consent to Treatment**

I consent to the performance of those elective procedures, examinations, and the rendering of treatment by the medical provider and their designated office staff as is deemed elective in the medical provider's judgement.

_____ **Authorization / Assignment / Financial Responsibility**

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of our payment policies. Payment is required for all services at the time they are rendered. Payments for services are *non-refundable.*

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____

Signature of Patient (or guardian) Date

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Patient Name: _____ Date of Birth: _____ Date: _____

MAIN REASON(S) FOR TODAY'S VISIT

What are the main reason(s) for today's visit? _____

What are your concerns? fatigue dehydration allergies asthma muscle pain/inflammation low energy levels depression migraines cold/flu athletic performance other:_____

MEDICATION/MEDICAL HISTORY

1. Current Medications *(prescription, non-prescription, herbal, creams, sprays, pills, liquids, drops):*

   1._____ 4._____ 7._____

   2._____ 5._____ 8._____

   3._____ 6._____ 9._____

2. Drug Allergy/Intolerance: D*escribe when/what reaction occurred or (circle) None Known:*

   1._____ _____

   2._____ _____

   3._____ _____

6. Your preferred pharmacy and location? _____

7. Hospitalizations / Operations (include dates):

   1._____ 4. _____

   2. _____ 5. _____

   3. _____ 6. _____

8. Other problems? *(please circle any that you have now or have had in the past)*

Asthma	Hemochromatosis	Sarcoidosis
Cardiac Arrhythmias	High/Low Blood Pressure	Seizure disorders
Cancer of _____	Hypo/Hyperthyroidism	Sickle Cell Anemia
Chronic infections	Kidney Disease	Systemic Lupus Erythematosus
Clotting Disorder	Liver Disease	
Congestive Heart Failure	Multiple Sclerosis	
Diabetes	Peripheral Edema	
Diarrhea	Peripheral Neuropathy	
G6PD deficiency	Other:_____	