ACTIVE infusions

DATE: _____

PATIENT INFORMATION

Patient Name: First_____MI_____ Last_____SS# _____

DOB:_____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □Life Partner

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined

Ethnicity: □ Not Hispanic/Latino □Hispanic/Latino □ Declined

Preferred Language: English_____ Spanish_____ Other_____

Do you have any communication difficulties/ special needs? Please circle. Hearing Loss Interpreter Required Reading Difficulty Sight Impaired

If yes, please list: _____

Address: _____ City_____St_____Zip _____

Phone: Home_____Cell_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes, I agree to receiving correspondence from Active Infusions

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School:_____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____ Last_____

Relationship: Spouse Guardian Other (Please Specify): _____

Address: _____ City_____St_____Zip_____

Phone: Home_____ Cell_____

Email Address _____

Employer: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone Cell_____ Home_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ **Do Not Release Information**

I authorize Active Infusions LLC and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Active Infusions LLC of changes or update. I authorize Active Infusions LLC to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____
Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Name _____ Relationship_____
Phone _____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION

Insurance

Primary Insurance_____ ID _____ Gp: _____

Policy Holder Name:_____

Relationship (Circle One)Self Spouse Guardian Other_____

SS#_____Policy Holder's DOB_____ Employer_____

Secondary Insurance_____ ID: _____ Gp:_____

Policy Holder Name:_____

Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

PRIVACY PRACTICES

Our office, physicians and staff, are committed to securing the privacy of your health information

Signature_____ Date:_____

FINANCIAL AND PAYMENT GUIDELINES

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.
I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment that the clinic may charge a cancellation fee. I authorize direct payment of my insurance benefits to Active Infusions LLC for services rendered to myself or dependents. Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits. Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
Active Infusions LLC or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

CONSENT TO CREDIT BUREAU INQUIRIES

I hereby consent to credit bureau inquires and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process I understand that these collection attempts could be performed by Active Infusions LLC or its affiliates/agents including, without limitation, any account management companies, independent contractors or collections agents.
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CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider. I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
I further authorize and request that insurance payments be directed to Active Infiusions LLC.
Name _____ Relationship_____
Phone_____

I have read, fully understand and agree to the above **medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment** and **release of medical information & insurance authorization**. I also certify that all of the information, provided is complete and accurate.

Patient Name _____

Signature _____Date_____

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infusions