ACTIVE infusions

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: _____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [] Student [ ] Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

Active Infusions Inc reserves the right to charge a fee for any scheduled visits that are cancelled with less than 24 hours notice or are missed without calling to cancel (no show). Cancellation Fee schedule is $50 to cover the cost of the Nurse's time.

Patient / Guardian Signature: _____ Date: _____

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

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 Infusions LLC.

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.

Privacy Practices Acknowledgement

I certify that I have been made aware of Active Infusions' **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Active Infusions' health care operations. The Notice also describes my rights and Active Infusions' duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Active Infusions' web site at www.activeinfusions.com. I may request that a copy be mailed to me by calling **240-200-4464.**

Active Infusions Inc reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by calling the above number and requesting that it be mailed to me, by asking for one at the time of my next appointment, or by accessing the Active Infusions website listed above for the latest version.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____

DATE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY