



Infusion Associates
 3230 Eagle Park NE, Suite 101
 Grand Rapids, MI 49525
 Phone: 616-954-0600 Fax: 616-954-1675

Today's Date: ____/____/____

PATIENT INFORMATION

Patient Name: _____ **Sex: M F**
First M Last

Address: _____ **Birth Date:** ____/____/____
Street City St Zip

Social Security # _____ **Married** **Single** **Divorced** **Widow**

Home Telephone #: () _____ - _____ **Work #:** () _____ - _____ **Cell #:** () _____ - _____

If we need to contact you at home, may we leave a message? Yes No **Name of Employer** _____

In case of emergency, contact: Name _____ Phone #: _____ Relationship: _____

**I authorize Infusion Associates, NE to discuss my medical condition/information with my emergency contact.*

Email address: _____

Referring Physician: _____ Phone #: () _____ - _____

Primary Care Physician: _____ Phone #: () _____ - _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy #: _____

Policy #: _____

Policy Holder Name _____

Policy Holder Name _____

Policy Holder Date of Birth _____

Policy Holder Date of Birth _____

Worker's Compensation Case: Yes No

Auto Accident: Yes No

Current Medications: See List

Past Medical History: See List

Allergies: _____

Reason for treatment: _____ Height: _____ Weight: _____

REQUEST FOR SHARING OF PERSONAL HEALTH INFORMATION WITH PERSON OTHER THAN PATIENT:

1. _____ Relationship to patient: _____

2. _____ Relationship to patient: _____

3. _____ Relationship to patient: _____

Signature of Patient or Authorized Representative _____ Date: ____/____/____

ALL MEDICARE PATIENTS MUST READ & SIGN:

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on behalf to Infusion Associates, doing business as Infusion Associates, NE. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Authorized Representative

Date: ____ / ____ / ____

ALL PATIENTS WITH INSURANCE OTHER THAN MEDICARE MUST READ & SIGN:

Assignment and Release

I, the undersigned, have insurance coverage and assign directly to Infusion Associates, doing business as Infusion Associates, NE all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. I understand that I am responsible for obtaining any authorizations necessary for services rendered. I understand that there are many different types of coverage within a given insurance company. Therefore, I may receive a billing for any Non-covered Benefits.

Signature of Patient or Authorized Representative

Date: ____ / ____ / ____

ALL PATIENTS WITH NO INSURANCE MUST READ & SIGN:

I, the undersigned, do not have insurance coverage and I understand that I am solely responsible for any and all services rendered. I understand the services must be paid in full upon receipt of statement unless other arrangements are made with the billing office.

Signature of Patient or Responsible Party

Date: ____ / ____ / ____

RELEASE OF INFORMATION:

I authorize Infusion Associates, doing business as Infusion Associates, NE to release any and all medical information contained within my medical records to referring Physicians, hospitals, laboratories, therapists, pain clinics, or a specifically named location in the course of my treatment under a physician or nurse practitioner at Infusion Associates, NE. This information may include my physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS, ARC, and/or psychological information.

This authorization is in effect until I revoke it.

Signature of Patient or Authorized Representative

Date: ____ / ____ / ____

CONSENT TO TREATMENT:

- I hereby request services of *Infusion Associates, NE* and I consent to such treatment, medications, and procedures as are ordered by my Physician and my Physician’s associates to be provided by *Infusion Associates, NE*. I agree that *Infusion Associates, NE* is not liable for any act or omission when following a Physician’s Instructions. I also understand that if I am in a condition to need hospitalization or special services during the course of my care which are not provided by *Infusion Associates, NE*, the services and hospitalization must be arranged by me, my legal guardian/representative, or my Physician, and are my responsibility.
- I will comply with all medically necessary procedures and treatments performed at the center.
- If my account balance becomes overdue and is placed with a collection or legal agency, I agree to pay all attorney or collection agency fees associated with my delinquent account.
- I, the undersigned, give the authorization to *Infusion Associates, NE* to obtain any of my medical records, mailed or faxed, pertinent to my medical condition.
- Authorization to Test and Release Information – You are hereby notified pursuant to Michigan law that as a patient of this facility, you may be tested for the presence of HIV or an HIV antibody without your consent if any health care professional or other facility employee sustains percutaneous, mucous membrane, or open wound exposure to your blood or other body fluids. This test is permitted by Michigan Law, and is for your protection as well as the protection of the Physicians, nurses, and other employees of *Infusion Associates, NE*.
- I acknowledge receipt of the Notice of Privacy Practices for *Infusion Associates, NE*.

Signature of Patient or Authorized Representative

Date: ____ / ____ / ____