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

PATIENT INFORMATION

Today's Date: _____/_____/_____

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 call you at home, may we leave a message? ☐ Yes ☐ No **Name of Employer**_____

In case of emergency -contact name and phone #: _____
Name Phone# Relationship

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

***To our patients: we ask all patients to show their insurance cards*

Current Medications: ☐ See List **Past Medical History:** ☐ See List

Allergies: _____

Reason for treatment: _____ Height: _____ Weight: _____

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 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, 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 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 the center.

(See Other Side)

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

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 Asssociates, 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.

_____ Date: ____/____/____

Signature of Patient or Authorized Representative

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.

_____ Date: ____/____/____

Signature of Patient/Insured or Authorized Representative

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 that services must be paid in full upon receipt of statement unless other arrangements are made with the billing office.

_____ Date: ____/____/____

Signature of Patient or Responsible Party

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 of 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.

_____ Date: ____/____/____

Signature of Patient or Authorized Representative

REQUEST FOR RESTRICTION AND SHARING OF INFORMATION WITH PERSON OTHER THAN PATIENT:

I authorize Infusion Associates, NE to discuss my medical condition / information to the following names:

1. _____ Relationship to patient: _____

2. _____ Relationship to patient: _____

3. _____ Relationship to patient: _____

_____ Date: ____/____/____

Signature of Patient or Authorized Representative