



**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

Do you have an **ADVANCED DIRECTIVE / DO NOT RESUSCITATE ORDER**?  Yes  No  
*\*\*If yes please provide a copy for our office*

In case of emergency -contact name and phone #: \_\_\_\_\_  
*Name Phone# Relationship*

**Referring Physician:** \_\_\_\_\_ **Phone #** ( ) - \_\_\_ - \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone #** ( ) - \_\_\_ - \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

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:** \_\_\_\_\_

Have you received this medication before?  Yes  No Any reaction?  Yes  No

**ALL PATIENTS MUST READ & SIGN:**

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.

\_\_\_\_\_  
*Signature of Patient* **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 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.

\_\_\_\_\_  
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 Hospitalist of West Michigan, PC 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 Hospitalist of West Michigan, PC 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/Insured 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 that 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 Hospitalist of West Michigan, PC 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.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_