Initial Visit Medical Intake Form

Name ____ Date ____________________

Email ____________________________________ Cell # ___________________ Date of Birth ____________

Address ____

City _____________________________ State _____________ Zip Code _____________________________

Emergency Contact ___________________________________ Phone ________________________________

Physician's Name _____________________________________ Phone ________________________________

How did you hear about Rejuvenetix? ____

Chief Complaint or Current Symptoms: ____

Past Medical History – Circle all that apply:

Hypertension	Diabetes	Fibromyalgia
Liver or Kidney Disease	Clotting / Bleeding Disorder	Asthma
Heart Disease	Leber's Optic Neuropathy	Fatigue
COPD	HIV / AIDS	Macular Degeneration
Lung Disease	Depression / Anxiety	Spinal / Joint Pain
Autoimmune Disorders	Lyme Disease	Cancer (specify):______________

Do you have any other health or medical conditions? ____

Drug ALLERGIES? **Yes / No.** Please list: ____

Do you take Aspirin, Plavix, or Coumadin? ____

CURRENT MEDICATIONS

Name:	**Dose:**	**Frequency:**

Female Clients – Are you pregnant or trying to become pregnant? **Yes** **No**
If yes, what week are you in? __________
Are you currently breastfeeding? **Yes** **No**

I certify that the above information is correct to my knowledge and I have not omitted any details about my medical condition or medical history. I am aware that it is my responsibility to inform Rejuvenetix of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures. I hereby release Rejuvenetix from liability, without limitation, from any injuries that occur to me as a result of not providing current and correct medical history information in this form. I consent to receive recurring automated marketing by text message and through email.

Signature ____Date ____________________

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

1) Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, or others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the business, and any other required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, if you are paying with a HAS/FSA card, it may require that your relevant protected health information be disclosed to the health plan for approval.

Healthcare Operation: We may disclose, as needed, your protected health information in order to support the business activities of the company. These activities include, but are not limited to, quality assessment activities, employee review activities, training staff, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to an emergency medical technician (EMT) or registered nurse (RN) that may be conducting services at your home. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food or Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2) Your Rights

You have the right to inspect and copy your protected health information. Under Federal Law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
The Physician or Business Practice is not required to agree to a restriction that you may request. If the Physician or Business Practice believes it is in your best interest to permit use and disclose your protected health information, then your protected health information will be restricted. You then have the right to use another healthcare professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You may have the right to have your physician amend your protected health information. I f we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by email / mail of any changes. You then have the right to object or withdraw as provided by this notice.

3) Complaints

If you believe your rights are being denied or your health information is not being protected, you can:

- File a complaint at http://hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748
- You may file a complaint with us by notifying our privacy contact of your complaint.

May we phone, email, or send a text to confirm appointments? YES NO
Do we have permission to leave a voice message? YES NO
Are there any members of your family that we may discuss your medical information with? YES NO

If yes, please write names: ____

This notice was published and becomes effective on/or before January 1, 2022

By signing this form, you consent and acknowledge this agreement to the terms set forth in the HIPAA Notice of Privacy Practices form and any subsequent changes in office policy. You understand that this consent shall remain in force from this time forward. Your signature acknowledges that I have been provided access to this Notice of our Privacy Practices.

Print Name:________________________Signature:___________________________Date:_____________

Informed Consent & Waiver of Liability

Please read and initial below

_____ I have informed the nurse and/or EMT of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or EMT of my current medical / health conditions and medical history.

_____ I have been informed of intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

_____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

_____ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:

Occasionally: Discomfort, bruising and pain at the site of injection.
Rarely: Nutrient IVs can cause irregular heartbeat (if administered to a patient who has a pre-existing cardiac arrhythmia condition), light-headedness, muscle cramps after the IV administration, or phlebitis (irritation) at the injection site.
Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

_____ Contraindications to certain IV drips: High blood pressure or uncontrolled blood pressure, Kidney failure, End stage kidney disease, bleeding or clotting disorders, Myasthenia Gravis, individuals taking Digoxin, Leber's Optic Neuropathy, and heart disease (History of MI, Arrhythmias, cardiomyopathy, Congestive heart failure etc)

_____ I will remove the Co-Adhesive Bandage/Coban within 30 minutes of application

_____ I am aware of possible side effects and contraindications

_____ I have read and fully understand the consent form I am signing. All my questions have been addressed to my satisfaction.

_____ I am 18 years of age or older or consent was provided by my Legal Guardian.

The undersigned does hereby completely and fully release and discharge Rejuvenetix and its employees of any obligation, liability, and/or responsibility for any complications arising for this IV treatment.

Patients Name (Printed) __________________________________ Date ___________________

Patients Signature ______________________________________ Date ___________________