Lone Star Infusion

Information and Medical History

Patient Information

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____

Psychiatric or Pain Doctor(s) _____ Phone _____

_____ _____

How did you hear about us? (Physician Referral, Web Search, Advertisement, Other)

_____

Patient Representative and Responsible Party for Payment (if different than patient)

Name _____ Relationship to Patient _____ Phone _____

Emergency / Authorized Contacts with whom we may share health information, in addition to Patient Representative

Name _____ Relationship to Patient _____ Phone _____

Medical Information

Height _____ Weight _____

Current or past medical conditions (Check all that apply)

- ☐ Uncontrolled high blood pressure
- ☐ Heart disease/congestive heart failure
- ☐ Stroke/Delirium
- ☐ Pulmonary hypertension
- ☐ Cerebral aneurysm/Intracranial hypertension
- ☐ Pregnant/planning to become pregnant
- ☐ Raised intraocular pressure
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Brain tumors/brain surgery
- ☐ Thoughts of suicide
- ☐ Liver/Kidney disease

Recreational drug use:

- ☐ Tobacco
- ☐ Alcohol: How much per week _____
- ☐ Other recreational drug use _____

Allergies / Adverse Reactions / Problems with previous anesthesia experiences

_____

Lone Star Infusion

Information and Medical History continued

Reason(s) for pursuing treatment with Lone Star Infusion

Current or past psychiatric or pain diagnoses

Treatment history

Past medications you've tried for your Psychiatric or Pain Diagnoses

ALL current medications

Other medical conditions or any other information you would like to provide

Patient Name

Date of Birth

Signature of Patient or Patient Representative

Date

For Office Use

Signature

Date

Lone Star Infusion

Authorizations

Authorization for Release of Information

I hereby authorize Lone Star Infusion to obtain from any source and examine and use, or discuss and disclose and provide any information necessary regarding the patient with insurance companies and with health care practitioners involved in the care of the patient. These communications of information may include unencrypted electronic communications. This authorization to obtain and release information is valid until revoked. The undersigned may revoke this consent in writing at any time, except with regard to information that has already been shared or disclosures that have already been made in reliance on such consent.

Electronic Communications Authorization

I hereby authorize Lone Star Infusion to communicate with me using electronic communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to Lone Star Infusion or that I have used to initiate contact with Lone Star Infusion. These communications may include appointment information, protected health information and confidential information. I understand that these electronic communications are not encrypted.

Acknowledgment of Review of Notice of Privacy Practices

I have received and reviewed the Lone Star Infusion Notice of Privacy Practices.

Treatment Authorization

I have the legal right to consent to medical and surgical treatment because I am the patient or I am the patient representative. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Lone Star Infusion and their designated associates or assistants believe are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers of Lone Star Infusion to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

Agreement to Pay

I understand that I am directly responsible for all charges incurred for medical services for the patient. I furthermore agree to pay interest, collection expenses and attorney's fees incurred to collect any amount I may owe.

I acknowledge that I have read (or had read to me) and fully understand the information on this form.

Patient Name	Date of Birth
Signature of Patient or Patient Representative	Date

Lone Star Infusion

General Policies

The following are general policies of Lone Star Infusion.

Payment

- Payment is due at the time of service.
- Payments may be made with cash or credit card.

Insurance

- Lone Star Infusion is not contracted with insurance companies, and does not file claims for services.
- If a patient or patient representative wishes to pursue reimbursement from their insurers it is their responsibility to do so, including assembling and filing the necessary documents and directing the insurers to send any such reimbursements directly to the patient or patient representative. At the patient's request Lone Star Infusion will provide receipts for service containing procedure codes that may be used for pursuing reimbursement.

Appointments

- Services are by appointment only. Treatments are typically offered on Wednesdays and Saturdays.
- Lone Star Infusion may provide reminder phone calls or emails regarding a scheduled appointment, but it is the responsibility of the patient or patient's representative to be aware of the appointment date and time and to arrive on time for a scheduled appointment whether or not reminder communications have been received.
- Arriving late places a burden on the staff and other patients. If a patient arrives late for an appointment the staff will attempt to fit the patient into the schedule and provide treatment that day. However, if this is not possible, the patient will be considered a no-show. Arriving more than 15 minutes late for your appointment will be considered a no-show.

No-Shows and Late Cancellations

- No-Shows or late cancellations place an extra burden on the staff and other patients of Lone Star Infusion. You must give 24 hour notice of a cancellation by email or text.
- No-shows and late cancellations are subject to a $375 fee.

Prescriptions

Lone Star Infusion provides NO prescriptions.

Communications for Regular and Urgent Matters

- If you have a life threatening emergency you should call 911. For other urgent matters, you are encouraged to direct inquiries to your primary care physician or specialty physicians.
- If you have an urgent matter, that is related specifically to treatment you have received from Lone Star Infusion, you may contact Lone Star Infusion during business hours to speak with the doctor on call.
- The preferred form of contact with Lone Star Infusion is email. Emails are checked regularly, and we will make every effort to respond promptly.

Termination

In some cases it may be necessary to terminate any physician-patient relationship and forgo further treatment(s) by Lone Star Infusion for a patient. Termination may occur at any time and may be initiated by either the physician or the patient. Reasons for termination by the physician may include non-compliance with treatment, missed appointments, cancellations or other factors. Lone Star Infusion will continue to provide care for 30 days after notice of termination, when appropriate, in order for the patient to arrange treatment with a new provider.

I acknowledge that I have read (or had read to me) and fully understand the information on this form.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Patient Representative Date