Lone Star Infusion PLLC

New Patient Registration

Welcome to Lone Star Infusion, PLLC

Infusion therapy treatments offer relief for many patients and may provide relief for you. We recognize that choosing to move forward with these treatments can be challenging and requires a significant commitment. We look forward to working with you as partners in your care. Please contact us at any time with questions, or with comments, or for more information.

Sincerely,

Dr. Allison Wells
mail@lonestarinfusion.com
281-719-9300

To register as a new patient please complete and submit the forms in this packet:

- ☐ General Information - 1 page
- ☐ Medical History - 2 pages
- ☐ Consents and Authorizations - 1 page
- ☐ Consent to Treatment - 2 pages
- ☐ Pre- and Post-Procedure Instructions - 1 page
- ☐ General Policies - 1 page
- ☐ Notice of Privacy Practices - 2 pages
- ☐ Physician Referral - 1 page

With respect to the Physician Referral please note: We believe in the team approach to medicine, and we recommend a physician referral. We do not require one. Our minimum requirement is that patients have, and list in their paperwork, a psychiatric professional who they can rely upon for their psychiatric needs.

To submit the completed forms:

Mail: Lone Star Infusion, PLLC
14740 Barryknoll Ln #140
Houston, TX 77079

Fax: 281-719-9393

Or email: mail@lonestarinfusion.com

Scheduling your treatment:

Contact us at any time to schedule your treatments.

Lone Star Infusion PLLC

General Information

Patient Information

First Name | Last Name | Date of Birth

Address | City | State | Zip

Email | Primary Phone

Gender | SSN | Driver's License Num. & State

Primary Care Doctor | 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)

First Name | Last Name | Date of Birth

Address | City | State | Zip

Email | Primary Phone

SSN | Driver's License Num. & State | Relationship to Patient

Emergency Contact

Name | Relationship to Patient | Phone

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

Name | Relationship to Patient

Name | Relationship to Patient

Signature of Patient or Patient Representative | Date

Lone Star Infusion PLLC

Medical History

Patient Name _____ Date of Birth _____

Reason(s) for pursuing treatment with Lone Star Infusion, PLLC

Current or Past Psychiatric or Pain Diagnoses

Treatment history

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

ALL Current Medications

Recreational Drug Use (Check all that apply)

- ☐ Tobacco use
- ☐ Alcohol use
- ☐ Other recreational drug use (Please List)

Past Surgeries

Any Problems with previous anesthesia experiences

Allergies or Adverse Reactions

Lone Star Infusion PLLC

Medical History continued

Patient Name _____ Date of Birth _____

Height _____ Weight _____

Current or Past Medical Conditions (Check all that apply)

- ☐ Uncontrolled high blood pressure
- ☐ Heart disease or congestive heart failure
- ☐ Stroke
- ☐ Pulmonary hypertension
- ☐ Delirium
- ☐ Cerebral aneurysm
- ☐ Intracranial hypertension
- ☐ Raised intraocular pressure
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Brain tumors or brain surgery
- ☐ Thoughts of suicide
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Other Medical Conditions (Please list any other medical conditions):

_____

_____

Are you currently pregnant or breast feeding or planning on becoming pregnant in the near future

_____

Any other information you would like to provide

_____

_____

_____

_____ _____

Signature of Patient or Patient Representative Date

For Office Use

Physician _____ Date _____

Lone Star Infusion PLLC

Consents and Authorizations

Patient Name _____ Date of Birth _____

Authorization for Release of Information

I hereby authorize Lone Star Infusion, PLLC 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.

_____ _____
Signature of Patient or Patient Representative Date

Electronic Communications Authorization

I hereby authorize Lone Star Infusion, PLLC 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, PLLC or that I have used to initiate contact with Lone Star Infusion, PLLC. These communications may include appointment information, protected health information and confidential information . I understand that these electronic communications are not encrypted.

_____ _____
Signature of Patient or Patient Representative Date

Acknowledgment of Review of Notice of Privacy Practices

I have received and reviewed the Lone Star Infusion, PLLC's Notice of Privacy Practices.

_____ _____
Signature of Patient or Patient Representative Date

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, PLLC 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, PLLC to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

_____ _____
Signature of Patient or Patient Representative Date

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.

_____ _____
Signature of Patient or Patient Representative Date

Lone Star Infusion PLLC

Consent to Treatment

Patient Name _____ Date of Birth _____

I have the legal right to consent to medical and surgical treatment because I am the patient or I am the patient representative. I consent to the procedure(s) or treatment(s) as outlined below to be performed by the physician(s) of Lone Star Infusion, PLLC and their staff, associates or assistants to whom the physician(s) performing the procedure may assign responsibilities.

The proposed procedure(s) or treatment(s) is:_____

The procedure(s) or treatment(s) has been explained to me in terms that I understand. The explanation included:

- The nature and extent of the procedure to be performed.
- The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences.
- The benefits of the procedure.
- The estimated period of incapacity.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I understand that:

- The drugs used and rates of infusion and duration of infusion will vary from patient to patient depending on the appropriate treatment plan for each patient. For a one-hour infusion there will be a recovery period in the office of approximately 20 minutes. For an infusion with a duration of up to four hours there will be a recovery period of approximately two hours.
- The use of Ketamine for the treatment of Mood Disorders and some other conditions, and the use of Ketamine for the treatment of Pain are considered investigational by the Food and Drug Administration.
- Ketamine is considered useful for the treatment of Mood Disorders and Pain and some other conditions. Lidocaine is considered useful for the treatment of Pain. Effects typically begin within several hours of treatment. It is also possible to have no positive effect from Ketamine or Lidocaine infusions.
- Side effects of Ketamine or Lidocaine may include dizziness, bad dreams, perceptual disturbances, confusion, elevations in blood pressure, euphoria, dizziness, increased libido and nausea. These side effects typically disappear at the end of the infusion.
- Ketamine and Lidocaine are anesthetic agents and the administration of these drugs is considered anesthesia. Complications with anesthesia can occur and include: drug reaction, the possibility of infection, bleeding or injury to blood vessels at the intravenous site. More severe complications could include depression of respiration and heart problems that could lead to serious consequences, including loss of life.

I agree to the following:

- I affirm that I am not pregnant or breastfeeding and that I have no intent of becoming pregnant in the near future. I fully understand the potential for risks to a developing embryo and fetus.
- I agree not to drive a car, operate machinery or make any legal decision within 24 hours after the procedure(s) or treatment(s).
- I agree to contact 911 in the event that I become suicidal or for any other life-threatening emergency following the procedure(s) or treatment(s).
- I agree to follow up with my referring physician or another licensed medical professional following the course of treatment, and at any time if my conditions worsens.
- I was given the opportunity to ask any questions I have regarding the procedure(s) or treatment(s) and I have had those questions answered to my satisfaction.
- I understand that I may consult or could have consulted with another physician about this procedure(s) or treatment(s).

Lone Star Infusion PLLC

Consent to Treatment continued

Patient Name _____ Date of Birth _____

- I understand that this procedure(s) or treatment(s) is completely voluntary and that I may pursue alternative treatments or no treatment at all for my condition(s).
- I understand that I have the right to refuse this procedure(s) or treatment(s) at any time prior to or during its performance.
- I authorize the physician to perform such additional procedures or treatments, including administering additional medications, which in his/her judgment are incidentally necessary or appropriate to carry out my care.
- If any unforeseen condition arises during this procedure(s) or treatment(s) which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize the physician to do whatever he/she deems advisable on my behalf.
- I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of this procedure(s).
- I acknowledge that I have read (or had read to me) and fully understand the information on this form. Furthermore, I certify that all my questions and concerns regarding the procedure(s) or treatment(s), its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize the physician to perform the above discussed procedure(s) or treatment(s).

_____ _____

Signature of Patient or Patient Representative Date & Time

_____

Witness to Signature

For Office Use

Physician _____ Date _____

Lone Star Infusion PLLC

Pre- and Post-Procedure Instructions

Patient Name _____ Date of Birth _____

Pre-Procedure Instructions

- Do not eat or drink in the 6 hours prior to your arrival time at the clinic. Failure to comply with this requirement may result in your treatment being cancelled and rescheduled.
- You may take your regular medicines as you normally would, including the morning of the infusion told otherwise by the physician.
- You may wear comfortable street clothes during the treatment. You may wish to bring a blanket or comfortable sweater, and your favorite music and headphones.
- Plan to arrive 15 minutes before your scheduled treatment time.
- Plan to recover for approximately 20 minutes after a one-hour infusion before being released to go home.
- For infusions that last up to four hours you should plan on recovering for approximately two hours before being released to go home.

Post-Procedure Instructions

- Arrange for someone to drive you home and for someone to stay with you throughout the next 24 hours.
- You should not drive a car, operate machinery or make any legal decision for the next 24 hours.
- You should not use any recreational drugs or alcohol for the next 24 hours.

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

_____ _____

Signature of Patient or Patient Representative Date

Lone Star Infusion PLLC

General Policies

Patient Name _____ Date of Birth _____

The following are general policies of Lone Star Infusion, PLLC. Please review them carefully.

Payment

- A non-refundable deposit of 60% of your fee may be collected prior to each appointment date. The balance of the fee is due at or before the scheduled treatment. If the complete payment is not rendered at the time of service, no service will be provided.
- Payments may be made with cash or credit card.

Insurance

- Lone Star Infusion, PLLC 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, PLLC 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, PLLC 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 30 minutes late for your appointment will be considered a no-show.

No-Shows and Late Cancellations

- Patients who fail to show to an appointment or who give less than 2 business days notice when cancelling or rescheduling an appointment place an extra burden on the staff and patients of Lone Star Infusion, PLLC.
- No-shows and late cancellations are subject to a $100 fee.

Prescriptions

Lone Star Infusion, PLLC 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, PLLC, you may contact Lone Star Infusion to speak with the doctor on call.
- The preferred form of contact with Lone Star Infusion, PLLC is email. Emails are checked regularly, and we will make every effort to respond to emails within 24 hours.

Termination

In some cases it may be necessary to terminate any physician-patient relationship and forgo further treatment(s) by Lone Star Infusion, PLLC 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, PLLC 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.

_____ _____

Signature of Patient or Patient Representative Date

Lone Star Infusion PLLC

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.

Your Health Information Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
- Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record or health and claims records and other health information we have about you. We may charge you a reasonable, cost-based fee for copying your information. You must make this request in writing.
- Ask us to correct your medical record: You can ask us to correct your health information or health and claims records if you think they are incorrect or incomplete. We may say no to your request, but we'll tell you why in writing within 60 days. You must make your request in writing and you must provide a reason for the request.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. You must make this request in writing and you must tell us how or where you wish to be contacted.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, or health care operations, or certain other disclosures (such as any you asked us to make). We will include each disclosure we made for the past six (6) years, unless you request a shorter time period. We will provide one accounting a year for free but will charge you a reasonable, cost-based fee if you ask for another one within 12 months.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can also file a complaint with the United States Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care; or Share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission: Marketing purposes; or Sale of your information.

Our Uses and Disclosures: How do we typically use or share your health information? We typically use or share your health information in the following ways.

- Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you. For Example, your doctor may send us information about your diagnosis and treatment plan so we can arrange appropriate treatment.
- Payment: We can use and share your health information to bill and get payment from your insurance company or a third party if appropriate. For example, we may need to provide your health plan with information about treatment you received so that your health plan will pay us or reimburse you for the treatment
- Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services or improve our services.
- Electronic: We may share your information electronically.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting suspected abuse, neglect, or domestic violence; reporting reactions to medications or product problems; or preventing or reducing a serious threat to anyone's health or safety.
- Do research. We can use or share your information for health research.
- Comply with the law. We will share information about you if state or federal laws require it. Including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official or correctional institution; with health oversight agencies for activities authorized by law; or for special government functions, such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Contact:

If you have any questions about this Notice of Privacy Practices you may contact our privacy officer by sending an email to mail@lonestarinfusion.com and referencing the Notice of Privacy Practices in the email subject line.

This notice is effective December 1, 2015.

Lone Star Infusion PLLC

Physician Referral

This form is to be completed by the referring physician.

Patient Name _____ Date of Birth _____

Physician Name _____ Specialty _____

Physician Email _____ Physician Phone _____

I am currently treating this patient for:

_____

_____

_____

This patient and I would like to initiate infusion therapy as an adjunct to the management of this illness.

I acknowledge that I may review information about this therapeutic option at www.lonestarinfusion.com and that I may contact Lone Star Infusion, PLLC to discuss the treatment.

I will follow up with this patient during and after the completion of the treatment course at Lone Star Infusion, PLLC or refer him or her to a licensed medical professional for follow-up.

_____ _____

Physician Signature Date

To return the completed form:

Email: mail@lonestarinfusion.com

Fax: 281-719-9393

Mail: Lone Star Infusion
14740 Barryknoll #140
Houston, TX 77079