Rockwall Rapid Care
2313 Ridge Road, Suite 105A
Rockwall, TX 75087
Office: (469) 769-5688 Fax: (469) 698-8686

Patient Intake Form

Reason for visit today?

_____

_____

_____

First Name:	
Middle Name:	
Last Name:	
Phone Number:	
Home Address:	
City:	
State:	
Zip Code:	
Date of Birth:	
Sex:	
Ethnicity (Hispanic, Non-Hispanic):	
Race (White, Asian, Black, Other):	
Parent / Guardian Full Name:	
Parent / Guardian Date of Birth:	
Email Address:	
Primary Care Provider Name:	

Medical History Intake Form

Patient Name _____

Chronic Medical Problems

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Previous Surgeries

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medication Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Family Health Problems

_____

_____

_____

_____

_____

_____

_____

Social History

Tobacco Use: Yes No Quit

Alcohol Use: Yes No Quit

Illicit Drug Use: Yes _____ No

Occupation: _____

Single Married Divorced Widowed

Consent to Treat & Financial Responsibility

I hereby authorize employees and agents of Rockwall Rapid Care (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Financial Responsibility Consent to Treat

I hereby authorize payment of medical benefits directly to Rockwall Rapid Care (hereinafter "RRC") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to RRC. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of RRC, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Acknowledgement of Receipt of Privacy Practices Notice

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. RRC is furnishing you with the attached notice, which provides information about how RRC and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of RRC's Notice of Health Information Practices.

Acknowledgement of Contact Methods

Note that for safety and convenience of patients, we require acceptance of practice interaction with patients through email, voicemail, and text in order for you to be a patient. This includes personal and health information to the patient and referring medical practices.

Method for contact

- X I acknowledge and authorize that my email address will be used to contact me and referring physicians about information for this visit
- X I acknowledge and authorize that my cellphone voice and voicemail will be used to contact me and referring physicians about information for this visit
- X I acknowledge and authorize that my cellphone text will be used to contact me and referring physicians about information for this visit

_____ _____

Patient Name (please print) **Signature of Patient, Parent, or Legal Guardian**

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IV Infusion Consent

Name _____

Date of Birth _____

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by the provider at **Rockwall Rapid Care**

(Initials)_____ I have informed the provider of any known allergies to drugs or other substances, or of any past reactions to anesthetics.

(Initials)_____ I have informed the provider of all current medications and supplements.

(Initials)_____ I have informed the provider of all known chronic health conditions including **Diabetes Mellitus, Kidney Disease Cardiac Arrythmia or G6PD Deficiency**.

Side Effects/Risks
(Initials)_____ 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:
   a. Occasionally to commonly:
      i. Discomfort, bruising and pain at the site of injection.
      ii. General feeling of warmth during and after injection
   b. Rarely:
      i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
      ii. Reactive Hypotension (or rapid drop in blood pressure)
      iii. Reactive Hypoglycemia (or rapid drop in blood sugar)
   c. Extremely Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

Benefits of intravenous therapy include:

1. Injectables are not affected by stomach, or intestinal absorption problems.
2. Total amount of infusion is available to the tissues.
3. Nutrients are forced into cells by means of a high concentration gradient.
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

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The Procedure
The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids) or chelation agents.
Your vitals will be measured prior to and after your infusion. What Safety Precautions Must You Take?

- Monitor the insertion site for signs and symptoms of infection (redness, swelling, discharge). Notify the clinic immediately. If your experience a sustained fever greater than 101, do not delay treatment and go to the ER as this can be a sign of sepsis.

- If you experience a minor side effect while you are at home, you should contact our office, otherwise contact your medical provider or call 911.

My Consent for Nutrient Infusion Therapy is Voluntary

(Initials)_____My request for nutrient infusion therapy as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse treatments at any time.

Statement of Person Giving Informed Consent
I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction. I am aware that other unforeseeable complications could occur. I do not expect the provider(s) to anticipate and or explain all risk and possible complications. I rely on the provider(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I give my consent to IV nutrient therapy.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

RELEASE OF MEDICAL INFORMATION
I hereby authorize **Rockwall Rapid Care** to disclose my medical records, to EMS, my spouse, and emergency contact. I also authorize **Rockwall Rapid Care** to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns.

_____ _____
Signature of Patient Date