IT IS WELL
Medispa

IV HYDRATION PATIENT INTAKE

Name: _____ **DOB**: _____ **Age**: _____

Street Address: _____

City: _____ **State:** _____ **Zip code**: _____

Phone: _____**Email:** _____

Emergency Contact/HIPPA CONSENT

I _____ authorize It Is Well Healthcare & Medispa to use or disclose my protected health information to carry out my treatment, for health care operations like quality reviews and in the event of a medical emergency. I authorize the person lists below to give or receive any information via telephone, mail, or in-person which would be of benefit to my care or wellbeing. I am aware that It Is Well Healthcare will not be responsible for the handling of any information released to the persons that I have listed below.

_____

Name (First/Last) **Relation** **Phone Number**

Reason For Visit: Please briefly describe why you are seeking ***IV infusion or injection therapy***? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better?

_____

_____

Allergies (Medications, foods, etc.):

_____

_____

_____

All Current Medications: (Please include OTC & supplements)

_____

_____

_____

_____

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Medical History

Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

□High Blood Pressure □Asthma
□Heart Murmur □COPD
□ Valve Disorder □Sleep Apnea
□Abnormal Rhythm □Shortness of Breath
□ Chest Pain □Pulmonary Hypertension
□ Heart Attack □Lung Cancer
□ Cardiac Surgery or Stents □Other Lung Disorder _____
□ Congestive Heart Failure □Other Cardiac Disorder _____
□ Peripheral Artery Disease □ Thrombosis or DVT □ Aneurysm

GASTROINTESTINAL AND URINARY

□ Acid Reflux □Liver Disease
□ Bladder Disease □Hepatitis A, B, C
□ Kidney Disease □Other _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

□ Hyper/Hypo Thyroid □Rheumatoid Arthritis
□ Diabetes Type I Type II □Hx of DKA
□ Lupus □Other _____

NEUROLOGIC

□Stroke/TIA
□Multiple Sclerosis □ Parkinson's
□ Seizures – date of last seizure _____ □Alzheimer's

HEMATOLOGY

□ Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
□ MTHFR
□G6PD Deficiency

MUSCULOSKELETAL

□Back Pain □Degenerative Joint Disease
□ Carpal Tunnel Syndrome □Degenerative Disk Disease
□Fibromyalgia □Other_____

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PSYCHOLOGICAL
□ Depression
□ Anxiety or Panic Attacks
□Suicidal Ideations

CANCER
□ Location of cancer _____
□Chemotherapy □Radiation

WOMEN (non-menopausal)
Last Menstrual Period _____ Any chance that you are pregnant? **YES / NO**
Are you currently breastfeeding? **YES / NO**

PAIN
□CRPS □Fibromyalgia

Do you drink alcohol or abuse any types of drugs? If so, please explain:
_____

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?
_____

Would you like to tell us anything else that you feel like is important?
_____
_____

I attest that the information I have provided is true and accurate to the best of my knowledge:

_____
Print Name **Date**

_____
Signature

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It Is Well Healthcare & MediSpa Clinical Policies

PATIENT CONSENT FOR IV INFUSION AND INJECTION THERAPIES WITH IT IS WELL HEALTHCARE & MEDISPA

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____ Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at It Is Well Healthcare & Medispa. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____I understand that treatments used It Is Well Healthcare & MediSpa might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that It Is Well MediSpa are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at It Is Well Medispa.

_____I understand that there are ***no*** refunds for services or products rendered.

_____I understand that having an appointment with It Is Well Healthcare & Medispa does not necessarily entitle me to having an IV infusion or injection procedure performed. Every individual is different, and it is at the medical providers discretion to issue treatment.

_____I understand that I must maintain my follow up appointments and following post procedural care instructions to remain on treatment. It is important that It Is Well Healthcare & Medispa manages my treatment and it is at their discretion to provide me ongoing therapies if desired.

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

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_____I am ***voluntarily*** requesting treatment with It Is Well Healthcare & Medispa in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____I do not hold any medical practitioner of It Is Well Healthcare & Medispa responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold It Is Well Healthcare & Medispa harmless if an adverse event occurs during my treatment.

I have read, understand, and agree to all of the above statements.

Print Name: _____

Signature: _____Date_____

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HIPAA
NOTICE OF PRIVACY PRACTICES

In accordance with the law, It Is Well Healthcare supports and upholds all matters pertaining to the privacy of your protected health care information. We will fully adhere to all legal requirements regarding your protected health care information, but reserve the right to change our privacy practices at any time as permitted by the law. If our privacy practices change, we will post a notice in our reception area, and provide you with a copy of the document changes.

CLIENT CONSENT FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I hereby consent to the utilization and disclosure of my protected health information by It Is Well Healthcare. In addition, I give my consent to provide treatment and secure payment, and other health care operations as related to my care. I have read/reviewed the Privacy Practice Statement (as above), prior to signing this consent, I understand that It Is Well Healthcare is required by law to report suspected or diagnosed child abuse and neglect; and conditions identified as "reportable conditions" by statue to the State Public Health Office.

It Is Well Healthcare may mail to my home, or other designated location, may correspond with me via telephone, leave verbal messages on my voicemail, or speak with me in person, in reference to any items or issues that will assist in the provision of my care, payment, and or other health care operations such as, insurance item, follow-up communication, X-ray and / or laboratory results, or other, pertaining to my care. This includes the transfer of my protected health information (if required) by postal mail, as long as the consents are addressed to me personally and are marked "personal and confidential" or are delivered by It Is Well Healthcare.

I further realize that I have the right to request that It Is Well Healthcare, restrict the use / disclosure of my personal health information regarding treatment, payment, and / or other health care operations or activities. However, It Is Well Healthcare is not required to agree to my requested restrictions. If It Is Well Healthcare does not agree to my requested restrictions; they are bound by the legal constraints regarding the privacy and protection of my health care information

I have read and understand the Notice of Privacy Practices and Consent for Use and Disclosure of Protected Health Information

_____ _____

Print Name **Date:**

_____ _____

Signature **Date:**