

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
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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)



IT IS WELL

— Medspa —

IV HYDRATION PATIENT INTAKE

Medical History

Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> COPD | |
| <input type="checkbox"/> Valve Disorder | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Abnormal Rhythm | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pulmonary Hypertension | |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> Cardiac Surgery or Stents | <input type="checkbox"/> Other Lung Disorder _____ | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Other Cardiac Disorder _____ | |
| <input type="checkbox"/> Peripheral Artery Disease | <input type="checkbox"/> Thrombosis or DVT | <input type="checkbox"/> Aneurysm |

GASTROINTESTINAL AND URINARY

- | | |
|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |

METABOLIC/ENDOCRINE/AUTOIMMUNE

- | | |
|--|---|
| <input type="checkbox"/> Hyper/Hypo Thyroid | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes Type I Type II | <input type="checkbox"/> Hx of DKA |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Other _____ |

NEUROLOGIC

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Stroke/TIA | |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Seizures – date of last seizure _____ | <input type="checkbox"/> Alzheimer's |

HEMATOLOGY

- | |
|---|
| <input type="checkbox"/> Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell) |
| <input type="checkbox"/> MTHFR |
| <input type="checkbox"/> G6PD Deficiency |

MUSCULOSKELETAL

- | | |
|---|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Degenerative Joint Disease |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Degenerative Disk Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other _____ |



IT IS WELL

— Melissa —

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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



IT IS WELL

— MediSpa —

IV HYDRATION PATIENT INTAKE

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.

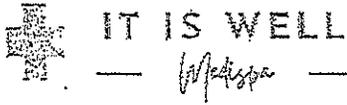
_____ I acknowledge that It Is Well MediSpa are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at It Is Well MediSpa.

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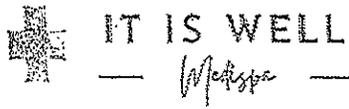
_____ I am *voluntarily* requesting treatment with It Is Well Healthcare & Medspa in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____ I do not hold any medical practitioner of It Is Well Healthcare & Medspa 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 & Medspa 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 statute 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: