PARAGON HEALTHCARE

Paragon Infusion Centers
Patient Information

Please complete the following form as accurately as you are able. Inaccurate and/or incomplete information can delay our ability to authorize your treatments, obtain referrals, and file your insurance claims for payment resulting in possible delays in your treatment.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: _____ ☐ Male ☐ Female SSN: _____

Phone Number: _____ Alternate Phone Number: _____

Address: _____

Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Is this your first time as a patient in this infusion center? ☐ Yes ☐ No

If no, when were you here last? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

_____

What Physician sent you to our infusion center: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____

Policy ID#:_____ Group #: _____

Is the policy holder the same as the patient? ☐ Yes ☐ No

If No, Policy Holder: _____ DOB: _____

SSN: _____ Relation to patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____

Policy ID#:_____ Group #: _____

Is the policy holder the same as the patient? ☐ Yes ☐ No

If No, Policy Holder: _____ DOB: _____

SSN: _____ Relation to patient: _____

TERTIARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____

Policy ID#:_____ Group #: _____

Is the policy holder the same as the patient? ☐ Yes ☐ No

If No, Policy Holder: _____ DOB: _____

SSN: _____ Relation to patient: _____

Paragon Infusion Centers
Patient Financial Agreement

Dear Patient,

This letter agreement sets forth our company's financial payment policy. I, the undersigned, understand and acknowledge that as a recipient of medical care at or by Innovative Infusions, LLC (a Paragon Healthcare, Inc. subsidiary) ("II" or "we") I am responsible for all charges regardless of my circumstances for reimbursement. I understand that a fee is charged for all medical services including, but not limited to, visits, treatments, infusion or injection services, examinations and/or medical reports. I acknowledge and agree that I have the primary duty and obligation to pay PHI for such medical services, notwithstanding, any contract I may have with any third party payer (e.g., Insurance company, employer, etc.).

As a courtesy, we will attempt to verify your insurance coverage, if any, and **estimate** the amount you may owe for services provided (e.g. co-pay, deductible, co-insurance, etc.) should insurance apply. However, some or all of the services provided may not be covered by your insurance, and you are responsible for any and all fees not covered or only partially covered by insurance. It is your sole responsibility to timely provide us with accurate and current insurance information. Your insurance is a contract between you and your insurance company. It is your responsibility to know and understand the level of service covered by your insurance.

I, the undersigned, hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes II and all parties it deems necessary to submit claims to obtain benefits and reimbursement for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to II all benefits. I understand I am ultimately financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account in accordance with my insurance company's assignment. Any unpaid charges are my responsibility.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances. Should I fail to pay unpaid charges for more than 30 days, I authorize unpaid charges to be charged to the credit card provided and on file (if any). Unpaid charges over 60 days will incur a monthly service fee of at least $25.00. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill. I understand and agree that some additional charges may come through from my treatments that are not included in the initial estimated bill. There is a $25.00 service charge for each and every returned check.

I give my consent to II to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I acknowledge that I understand and agree to the terms outlined above:

_____ _____

Patient Signature *Date*

_____

Patient Name (Print)

Paragon Infusion Centers
Patient Consent For Treatment

I have been given sufficient information to make an informed decision and consent to treatment. I am aware of the potential benefits, side effects and contraindications of the infusion medication and infusion therapy that my physician has ordered. I understand that I have the right to refuse the recommended therapy at any time. I acknowledge that I have read and fully understand this consent, related documents, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature. No guarantees or promises have been made to me regarding the outcome of the treatment. I also authorize the company to photograph, video and/or use any other mediums which result in the permanent documentation of my image for safety, medical, scientific or educational purposes. I agree that any such photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the company so long as the manner of disposition shall be permanent destruction.

HEPATITIS B VIRUS CONSENT FOR TREATMENT

For patients on the following medications: Actemra, Cimzia, Orencia, Remicade, Rituxan, Simponi Aria: If I have not had a Hepatitis B Virus (HBV) vaccination or I refuse such vaccination, I understand that due to my exposure to potentially infectious material, I may be at risk of acquiring HBV. I understand that by not obtaining this vaccine, I continue to be at an increased risk of acquiring HBV, a serious disease.

PREGNANCY AND BREASTFEEDING CONSENT FOR TREATMENT

For females: Please check one (1) of the following:

- ☐ I am not pregnant now and have no reason to suspect that I am pregnant. I am aware of the potential risks, known and unknown, to the fetus if I become pregnant during treatment including miscarriage or congenital deformity. If I should become pregnant, I will notify the clinical staff immediately.
- ☐ I am pregnant, will continue treatment and am aware of the potential risks, known and unknown, to the fetus including miscarriage or congenital deformity.
- ☐ I am breastfeeding and will continue breastfeeding while receiving treatment. I am aware of the potential risks, known and unknown to my breastfeeding child while receiving treatment.

PATIENT PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside of these offices who are involved in my care and treatment for the purpose of providing health care services. Although all NPs, RNs and infusion center staff will attempt to conceal written medical information, I understand that other patients or staff in the infusion center may overhear the staff when medical information is provided to me. I further acknowledge that the infusion center is an open treatment area that may be monitored by video surveillance. By signing this page I give my consent to be monitored and recorded by video. By signing this page, I acknowledge that I have read and fully understand the above statement.

EMPLOYEE INCIDENT

In case of an employee needle stick injury or exposure to blood/body fluids, you consent to have your labs drawn by our clinical staff which would include, but not be limited to, Hepatitis B, Hepatitis C, and HIV.

RELEASE OF PATIENT INFORMATION

I, authorize my physician, the infusion center medical director, office staff and others outside of this office who are involved in my care and treatment for the purpose of providing medical care to leave messages and/or voicemails and discuss medical information with family members.

OR, I permit the release of information only to the following:

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

_____ _____
Patient or Responsible Party Signature *Date*

_____
Relationship to Patient

Innovative Infusions, LLC is a wholly owned subsidiary of Paragon Healthcare, Inc.

CONSENT for COMMUNICATION via E-MAIL and TEXT MESSAGE

(Provider – Patient)

I, _____, hereby consent to have the staff of Paragon Healthcare, Inc. and any of its subsidiaries ("Paragon"), which may include pharmacists, reimbursement and billing staff and nurse practitioners involved in my care communicate with me and my physicians, where appropriate, via e-mailing or text messaging regarding the following aspects of my medical care and treatment: test results, prescriptions, appointments, billing, etc. I understand that e-mail and/or text message is not a confidential method of communication and may have the following risks:

- Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Your employers and/or on-line services may have a right to inspect emails and texts sent through their systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection or errors can occur in the transmission.
- Emails and texts can be used as evidence in court.
- Emails and texts may not be a reliable means of communication.
- Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

I further understand that there is a risk that e-mail or text message communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail or text message communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e- mail or text message. I agree not to disclose sensitive medical information such as information relating to HIV, mental health or substance abuse. I understand and acknowledge that Paragon cannot guarantee the privacy, security or confidentiality of information transmitted via email or text. I understand that I may revoke my consent at any time by advising Paragon in writing.

Email Address: _____

Cell Phone Number for Text Messages:_____

_____ _____

Signature *Date*

PARAGON HEALTHCARE

Patient's Current Medications List

Patient Name: _____ DOB: _____ Today's Date: _____

Medication Name	Strength and Frequency	Comments

Allergies

Physicians and Specialties

REMICADE (infliximab) Consent and Disclosure

TO THE PATIENT (AND OTHERS LEGALLY RESPONSIBLE FOR THE PATIENT): You have the right as a patient, to be informed about your condition and how Infusion therapy medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment. I voluntarily request that Innovative Infusions, LLC, (dba Paragon Infusion Centers) "Paragon" and other affiliated health care personnel as they may deem necessary, treat my condition (or the condition of the person for whom I am responsible). I understand that the treatment is planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize to be treated.

I understand that no warranty or guarantee has been made regarding the results of treatment. I realize that there may be risks and hazards in treating this present health condition, with or without conventional medicine, and there may also be risks and hazards related to the planned treatment; including worsening of present symptoms, development of new symptoms, possible undesirable interactions between various treatments. Serious infusion reactions have been reported with REMICADE, including hives, difficulty breathing, and low blood pressure. Reactions have occurred during or after infusions. In clinical studies, some people experienced the following common side effects: respiratory infections (that may include sinus infections and sore throat), coughing, and stomach pain or mild reactions to infusion such as rash or itchy skin. The reports of serious infections, including tuberculosis (TB) and Reports of lymphoma (a type of cancer) in patients on REMICADE and other TNF blockers are rare but occur more often than in the general population. Some of these infections have been fatal. Nervous system disorders have also been reported.

I have been given an opportunity to ask questions about the treatment of this health condition using conventional methods with my ordering provider. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment with my ordering provider, and I believe that I have sufficient information to give this informed consent.

I certify that I have read this form (or have asked to have it read to me), and that I understand its contents. I also certify that neither Paragon nor any affiliated staff have made guarantees to me as to the success of this treatment.

_____ _____

Patient or Responsible Party Signature *Date*

_____

Relationship to Patient

_____

Patient Name (Print)

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