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: ________________________

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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)

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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

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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*

Patient's Current Medications List

Patient Name: ______________________________ DOB: ____________ Today's Date: ____________

Medication Name	Strength and Frequency	Comments

Allergies

Physicians and Specialties

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PARAGON HEALTHCARE

Guidelines for XOLAIR (Omalizumab) Patients

IMPORTANT: XOLAIR SHOULD ALWAYS BE INJECTED IN YOUR DOCTOR'S OFFICE

What is the most important information I should know about Xolair?

A severe allergic reaction called anaphylaxis has happened in some patients after they received Xolair. Anaphylaxis is a life threatening condition and can lead to death so get emergency medical treatment right away if systems occur.

Signs and symptoms of anaphylaxis include:

- Wheezing, shortness of breath, cough, chest tightness, or trouble breathing
- Low blood pressure, dizziness, fainting, rapid or weak heartbeat, anxiety, or feeling of "impending doom"
- Flushing, itching, hives or feeling warm
- Swelling of the throat or tongue, throat tightness, hoarse voice, or trouble swallowing
- Get emergency medical treatment right away if you have signs and symptoms of anaphylaxis after receiving Xolair.

Anaphylaxis from Xolair can happen:

Right after receiving Xolair injection or hours later.
After any Xolair injection.
Anaphylaxis has occurred after the first Xolair injection or after many injections.

Your healthcare provider should watch you for some time in the office for signs and symptoms of anaphylaxis after injecting Xolair. If you have any signs and symptoms of anaphylaxis, tell your healthcare provider right away.

Your healthcare provider should instruct you about getting emergency medical care if you have signs and symptoms of anaphylaxis after leaving the doctor's office.

WHAT IS XOLAIR?

Xolair is an injectable medicine for patients ages 12 and older with moderate to severe persistent allergic asthma whose asthma symptoms are not controlled by asthma medicines called inhaled corticosteroids. A skin or blood test is done to see if you have allergic asthma. Xolair is also used for chronic idiopathic urticaria in adults and adolescents (12 years of age and above) who remain symptomatic despite H1 antihistamine treatment

WHAT ELSE SHOULD I KNOW ABOUT XOLAIR?

You should not receive Xolair if you have ever had an allergic reaction to a Xolair injection. Do not change or stop taking any of your other asthma medications unless your healthcare provider tells you to do so. There are other possible side effects with Xolair. Talk to your doctor for more information.

You can also go to www.xolair.com or call 1-866-4XOLAIR (1-866-496-5247).

PARAGON
HEALTHCARE

Guidelines for XOLAIR (Omalizumab) Patients

THE MEDICAL DIRECTORS OF THE INFUSION CENTER HAVE ADOPTED THIS NEW WAIT TIME FOR USE IN OUR PRACTICE WITH OUR XOLAIR PATIENTS BASED ON THE FDA RECOMMENDATION AND NEW STUDIES.

ALL XOLAIR Patients

1. Patients receiving XOLAIR injections are to wait 120 minutes post injection for the 1st injection, 60 minutes post injection for injections 2 and 3, and 30 minutes post injection for all following injections.
2. All patients are to be given a prescription for (2) two EpiPens
3. All patients are to be given instruction on the indication and use of EpiPen.
4. Patients are to be instructed to keep EpiPen on person when leaving the clinic and for the next 24 hours.
5. Patients must go for immediate evaluation at our office or the nearest Emergency Room if the EpiPen is used.

I do herby acknowledge that I have read and understand the information provided to me, including the FDA Guidelines on Xolair provided on the previous page. I accept and understand the risk to myself, including possible anaphylaxis and other post-injection reactions. I also agree to abide in total compliance to the guidelines for Xolair and understand that any non-compliance to these guidelines may result in significant health risk for me and possible removal from future injections or transfer from the Infusion Center.

______________________________ *Patient or Responsible Party Signature*

______________ *Date*

______________________________ *Relationship to Patient*

______________________________ *Patient Name (Print)*

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