

CLIENT IV Vitamin /Nutrients

INTAKE EVALUATION

Name: _____ Date _____

Phone _____ / _____ - _____ email: _____

Street: _____ City _____

State _____ Zip _____ Emergency Contact: _____

DOB _____ / _____ / _____ Age _____ Male _____ Female _____ Height _____ Weight _____

What Service are you here for? _____

Why do you want this service? _____

How you found out about us: fax / friend / internet / Natural Awakenings Magazine /
(other) _____

What do you do for a living? _____

Did you ever work in: construction: yes / no | auto repair: yes / no | painting: yes / no | machine
shop: yes / no | chemical plant: yes / no | pottery: yes / no | dry cleaning: yes / no |

Allergies _____

Medications: Prescription/ Nonprescription/ Herbals/ Vitamins

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

Medication _____ Dose Frequency _____ Last Dose _____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Hypertension _____ Hepatitis _____ Renal _____ Respiratory _____
Diabetes _____ Stroke _____ Heart Disease _____ Seizures _____ Mental Health
Issues _____ Renal Disease _____ Abnormal Bleeding _____ Glaucoma _____

ARE YOU EXPERIENCING CONSTIPATION: yes / no

Does it feel like there is more feces stuck in you after having bowel movement?: yes / no

Do you have a diet with low fiber and high meat/cheese or processed foods: yes / no

Incontinence: yes / no | Pain: yes / no | Blood in Stool: yes / no | Hemorrhoids: yes / no |

Last Bowel Movement _____ Previous Interventions: None / Laxatives / Enemas / Other _____

Frequency of Bowel Movements _____ Color _____ Consistency: (circle all that apply): thin, thick, hard, soft, watery, small round, clay like

Are you experiencing?: Nausea: YES / NO; Dizziness: YES / NO; Vomiting: YES / NO; Pain: YES / NO.

Alcohol Use: yes / no | How Much: _____ How Often: _____ | How Long: _____

Tobacco Use: yes / no | Type: cigars ____; cigarettes ____ pipe ____ #per day _____

Do You Live w/Someone Who Smokes: yes / no | Current Recreational Drug Use: yes / no | Former Use: yes / no | Describe _____

Medical Conditions _____

Hospitalizations _____ Surgeries _____

How Is Your General Health? _____

Have You Been Able To Follow Prescribed Medications/Treatments? yes/no If "no" why not? _____

Family Physician _____

I _____ (patient name) acknowledge and understand that Kenneth Lewandowski, D.O. and IV Nutrients Company is NOT my primary Medical Doctor and ALL medical decisions regarding any current or future health conditions should be addressed by my primary care physician. IV Nutrients Company serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness.

X _____
Signature

Date

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, _____, (patient’s name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility’s Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility’s Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of PatientDate:

HIPAA Privacy Rule of Patient Authorization & Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient’s name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility’s notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility’s Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I’ve provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility’s procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient Date:

ALL CLIENTS 64 & Older MUST SIGN THIS!!

This agreement is entered into by and between IV Nutrients Company/ Kenneth Lewandowski, DO, (hereinafter called "Physician"), whose principal medical office is located at Suite 201, 90 Millburn Ave., Millburn NJ 07041 and

_____ (PRINT PATIENT NAME)

ADDRESS:

A. Background

A change in the Social Security Act, effective January 1, 1998, permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician was not permitted to charge a beneficiary more than a certain percentage in excess of the Medicare fee schedule amount (limiting charge). The law now permits physicians and beneficiaries to enter into private arrangements through a written contract under which the Beneficiary may agree to pay the Physician more than that which would be paid under the Medicare program.

However, beneficiaries and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare. This agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

B. Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.
2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.
3. Physician acknowledges that (s)he will not execute this contract at a time when the Beneficiary is facing an emergency or urgent healthcare situation.
4. Physician agrees to provide the beneficiary or his/her legal representative with a copy of this document before items or services are furnished to the beneficiary under its terms.
5. Physician agrees to submit copies of this contract to the Clinics for Medicare and Medicaid Services (CMS), upon the request of the CMS.

C. Obligations of Beneficiary

1. Beneficiary or his/her legal representative agrees to be fully responsible for payment of all items or services furnished by Physician and understand that no reimbursement will be provided under the Medicare program for such items or services.
2. Beneficiary or his/her legal representative acknowledges and understands that no limits under the Medicare program (including the limits under section 1848 (g) of the Social Security Act) apply to amounts that may be charged by Physician for such items or services.

