TwelveStone Infusion Center, LLC

TwelveStone HEALTH PARTNERS™

Infusion Patient Packet

Monday-Friday
8:00 AM to 4:30 PM
[by Appointment Only]

844-893-0012 Phone
800-223-4063 Fax
www.12stonehealth.com
8880 Cedar Springs Lane;
Ste 103 Knoxville, TN 37923

Thank you for choosing the TwelveStone Infusion Center. We look forward to serving you!

The Day of Your Infusion
On the day of your appointment, please arrive 15 minutes early. You will enter through the front door where a receptionist will show you to the Infusion Center waiting area.

Preparing for Your Infusion
Please be sure to drink at least 16 ounces of water, bring your completed new patient forms included with this letter, a list of your current medications, insurance card, and copayment. Please wear comfortable clothes and dress in layers. You are welcome to bring a blanket and pillow, your laptop/tablet, and whatever you might need to be comfortable and pass the time during your infusion.

What You Can Expect In Your Suite
Our ambulatory center offers private suites in a relaxed setting for your specialty infusion or injection. Every patient has access to a comfortable recliner, room for a guest (12 years and older) and a couch for seating, a large screen tv and soundbar, wireless internet, snacks and beverages.

When to Cancel
Please cancel your appointment if you have a fever, infection, are on antibiotics, have yellow/brown/green drainage, or have had live vaccines in the last 8-12 weeks. If you have any questions about whether you should receive your infusion, please contact your physician. If you need to cancel your appointment, please call at least 48 hours in advance. If you are more than 15 minutes late, you may be asked to reschedule.

Emergency
In the event of an emergency or reaction, please call 911 or contact your prescriber.

TwelveStone Infusion Center looks forward to caring for you.
If you have any questions or concerns, please feel free to call us at 615-278-3350.

John 12: 26 Whoever serves me must follow me; and where I am, my servant also will be. My Father will honor the one who serves me.

TwelveStone Infusion Centers, LLC
Notice of Privacy Practices
Effective Date: May, 7 2018

The TwelveStone Infusion Centers, LLC ("Infusion Center") understands that your health information is sensitive, and we are committed to protecting it. This Notice of Privacy Practices ("Notice") describes how your health information may be used and disclosed, and how you can get access to this information. Please review this document carefully.

Your Health Information: The Infusion Center creates a record of your care. Typically, this record contains information such as your symptoms, test results, diagnoses, treatment, and related medical information, as well as billing and insurance information. This Notice applies to all of the records related to your care that the Infusion Center creates or maintains.

How We Use Your Health Information: This Notice describes how we may use within our Infusion Center and disclose your health information. This Notice also describes your rights to access and control your health information.

Uses and Disclosures of Health Information Not Requiring Consent or Authorization: The following categories describe different ways that we use and disclose medical information without your authorization under most circumstances. While we set forth examples, not every potential use or disclosure in a category will be listed.

Treatment: We will use and disclose your health information to provide you with medical treatment or services. Your health information may be disclosed to physicians, providers, nurses, technicians, interns, and others involved in your care at the Infusion Center. We may also disclose your health information to other healthcare providers outside the Infusion Center who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your health information for payment and collection purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from you, your health plan (e.g. your insurance) and/or applicable third parties. Health information may be shared with the following: billing companies, insurance companies (private and government health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operations: Your health information may be used and disclosed for purposes of furthering day-to-day Infusion Center operations. We may use and disclose your health information for administrative, financial, legal, and quality improvement activities performed to operate the Infusion Center's business and to support our core functions of treatment and payment. For example, we may combine and assess the health information of our patients to evaluate the need for new services or treatment. We may use and disclose your health information to perform various functions (e.g. appointment reminders, accreditation; quality evaluations or records analysis; training staff, students, interns, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the Infusion Center). We may use your health information to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your health information with Business Associates who assist us in performing operational functions, but we will always obtain assurances from them to protect your health information the same as we do.

As Required by Law: We may have an obligation under federal, state, or local law to disclose your health information. For example, we may be required to report gunshot wounds, suspected abuse, or neglect.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

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Research: We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Food and Drug Administration (FDA): We may disclose to the FDA medical information related to FDA regulated products or activities to collect or report adverse events, product defects or problems, or biological product deviations, to track FDA-regulated products; to enable product recalls, repairs or replacement, or conduct post marketing surveillance.

Abuse, Neglect, Or Domestic Violence: We may disclose your health information if we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure or disciplinary actions or other government oversight activities. These activities are necessary for the government to monitor the healthcare system, government benefit programs, and compliance with law.

Judicial and Administrative Purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative, and law enforcement purposes.

Health or Safety: We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Law Enforcement Purposes: We may disclose your medical information to law enforcement officials in the following cases: as required by law to report wound or physical injury; in compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, subpoena, summons, or similar process; identification or location of a suspect, fugitive, material witness, or missing person; in limited circumstances when the individual is or may be the victim of a crime; about an individual who has died to alert law enforcement that the individual's death may have resulted from criminal conduct; related to criminal conduct that occurred on the Infusion Center's property; or in a medical emergency not on the Infusion Center's property to report the nature or location of a crime, the victim(s) of such crime, and the identity, description, and location of the criminal.

National Security and Intelligence Activities: We may release your health information to authorized federal officials for lawful intelligence, counterintelligence and other national security activities authorized by law.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information to a coroner or medical examiner to identify a deceased person, determine cause of death, or other purposes as authorized by law. We may disclose medical information to funeral directors so they can carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose medical information to organ procurement organizations or other entities engaged in the procurement, storage, or transplantation of organs, eyes, or tissue to facilitate organ, eye, or tissue donation and transplant.

Inmate or in Custody of Law Enforcement: If you are an inmate in a correctional institution or under lawful custody of law enforcement, we may disclose your health information to a correctional institution or law enforcement official as allowed or required by law.

Disaster Relief: We may use or disclose your health information to an authorized public or private entity to assist in disaster relief efforts.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

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Public Health: We may disclose your medical information for public health activities, including: for prevention or control of disease, injury, or disability; for reporting of disease, injury, or vital events such as birth or death; for public health surveillance, investigations or interventions; at the direction of a public health authority to an official of a foreign government agency acting in collaboration with a public health authority; to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect; to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition; for reporting of child abuse or neglect; under limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce related to a work-related illness or injury or a workplace-related medical surveillance.

Disclosure to Relatives, Close Friends and Other Caregivers: We may use or disclose your health information to a family member, other relative, a close friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we obtain your agreement or provide you with the opportunity to object to the disclosure and you do not object or if we reasonably infer that you do not object to the disclosure.

Patient Directory Information: Unless you tell us otherwise, we will include your name, location of the facility, and your general condition (good, fair etc.) in our patient directory and make this information available to anyone who asks for you by name.

Certain Limited Marketing Communications: we may provide refill reminders or communicate with you about a drug or biologic that is currently prescribed to you so long as any payment we receive for making the communication is reasonably related to our cost of making the communication. In addition, we may market to you in a face-to-face encounter and give you promotional gifts of nominal value without obtaining your written authorization.

Uses and Disclosures of Health Information Requiring Authorization: For uses and disclosures for purposes other than as described above, we are required to have your written authorization. Most uses and disclosures for marketing purposes (other than under the limited circumstances as described above) and disclosures that constitute the sale of your health information require your authorization. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already relied on your authorization. We will not use or disclose psychotherapy notes about you without your authorization except for use by the mental health professional who created the notes to provide treatment to you or to defend ourselves in a legal action or other proceeding brought by you.

Your Rights Regarding Your Health Information: You have certain rights with regard to your health information as described below.

Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions, we are not required to agree to a requested restriction unless the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service for which you have paid us out of pocket in full. If you wish to request additional restrictions, please contact the Privacy Officer. We will send you a written response.

Right to Receive Communications by Alternative Means/Locations: You may request in writing, and we will attempt to accommodate any reasonable request, to receive your health information by alternative means of communication or at alternative locations.

Right to Inspect and Copy Your Health Information: You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please submit a written request to the Privacy Officer. If you request copies, we may charge you a reasonable copy fee.

Right to Request Amendment to Your Record: You have the right to request that we amend your health information maintained in your record. If you desire to amend your record, please submit the request in writing to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of certain disclosures of your health information made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a 12- month period, we may charge you a reasonable fee for the accounting statement.

Right to Receive Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation, we will give you this Notice as soon as possible.

Further Information; Complaints: If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your health information, you may contact the Privacy Officer. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

Breach of Unsecured Health Information: You have the right to receive notification of any breach of your unsecured health information.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice at the Infusion Center and on our website at: **12stonehealth.com**. You can also request a copy of our Notice at any time. If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer.

Privacy Officer: If you have any questions, requests, or complaints, please contact:

Email: **info@12stonehealth.com**

Address: **TwelveStone Infusion Centers, LLC**
352 West Northfield Boulevard
Suite 3C
Murfreesboro, TN 37129-1539
Attn: Privacy Officer

Telephone: **(615) 278-3350**

X_____ _____

Patient Signature or Legal Representative Signature **Date**

_____ _____

If Signed by Legal Representative, Print Name **Relationship to Patient**

Patient Rights and Responsibilities

Your Rights:

Respectful and Safe Care

- Be given considerate, respectful and compassionate care.
- Be given care in a safe environment, free from abuse and neglect (verbal, mental, physical or sexual).
- Know the names and jobs of the people who care for you.
- Know when students, residents or other trainees are involved in your care.
- Have your culture and personal values, beliefs and wishes respected.
- Be treated without discrimination based on race, color, national origin, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, ethnicity, language or ability to pay.
- Be given a list of protective and advocacy services, when needed. These services help certain patients (e.g., children, elderly, disabled) exercise their rights and protect them from abuse and neglect.
- Ask for an estimate of charges before care is provided.

Effective Communication and Participation in Your Care

- Get information in a way you can understand. This includes sign language and foreign language interpreters and vision, speech and hearing aids provided free of charge.
- Be involved in your plan of care and discharge plan or request a discharge plan evaluation at any time.
- Involve your family in decisions about care.
- Ask questions and get a timely response to your questions or requests.
- Refuse care.
- Have someone with you for emotional support, unless that person interferes with your or others' rights, safety or health.
- Select someone to make health care decisions for you if at some point you are unable to make those decisions (and have all patient rights apply to that person).

Privacy and Confidentiality

- Have privacy and confidential treatment and communication about your care.
- Be given a copy of the HIPAA Notice of Privacy Practices.

Complaints and Grievances

- Complain and have your complaint reviewed without affecting your care.

Your Responsibilities:

- Provide accurate and complete information about your health, address, telephone number, date of birth, insurance carrier and employer.
- Call if you cannot keep your appointment.
- Be respectful of your Infusion Center team.
- Be considerate in language and conduct of other people and property, including being mindful of noise levels, privacy and number of visitors.

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- Be in control of your behavior if feeling angry.
- Give us a copy of your advance directive.
- Ask questions if there is anything you do not understand.
- Report unexpected changes in your health.
- Take responsibility for the consequences of refusing care or not following instructions.
- Pay your bills or work with us to find funding to meet your financial obligations.

Is compliance to medication therapy important?
TwelveStone Health Partners understands how crucial a client's compliance to their prescribed therapy is to the outcomes of the client therapy program for their specific disease state. Noncompliance or poor compliance to the client medication treatment plan significantly increases the risk of poor health outcomes while increasing the risk of an adverse event, overall cost of care, and/or negative impacts on quality of life.

TwelveStone Health Partners Clinical Management Program is designed to support the following primary goals:

- Optimal clinical outcomes as it relates to your infusion therapy
- Medication compliance
- Educated and knowledgeable clients in regard to their medication treatment plan, disease state(s)
- Assist with educating our patients on how to manage their medication confidently
- Medication therapy supported by evidence based clinical guidelines that are designed to achieve the best patient outcomes
- Reducing the risk of side effects and/or reactions that could lead to missed time from work or school, ER visits, unplanned doctor visits, increased healthcare costs, etc.

The staff of TwelveStone Health Partners works with the client, healthcare team and available resources to implement appropriate interventions that will improve a client's infusion experience.

Coordination of Care
Effective and efficient communication is the key to the success of coordination of care when utilizing a multidisciplinary team that includes but is not limited to the Health Partners, the pharmacist, nursing, physician, providers, the client/caregiver and other exterior sources to optimize the best client outcome based on evidence-based practice standards.

Mechanisms are in place to facilitate communication between all levels of the multidisciplinary team personnel, the practitioners, administration, clients, and their families.

Continuity of care is facilitated by established formal and informal communication mechanisms between all disciplines providing care (whether directly or under contract).

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These communication mechanisms include, but are not limited to:

a. Multidisciplinary team meetings
    i. Written documentation of communication
    ii. Fax
    iii. Electronic mail
    iv. In person
    v. Summaries (as needed)
    vi. Telephone communications and voicemail
    vii. Reporting from and to on-call staff, practitioners, and the client.
b. Ad hoc/Client Advocate case conferences when needed
c. Family meetings as appropriate

Communication for the coordination of care is ongoing throughout the course of services, care, and treatment. From day one of the referral, questions, assessments, and activities.

DRUG UTILIZATION REVIEW (DUR): For Your Safety

TwelveStone Health Partners has a Drug Utilization Review program. The goal of the program is to improve client care, optimize outcome, identify and prevent the risk of an adverse event and assess for overall drug cost to the client and the insurance provider.

DUR is a continuous defined systematic process. It involves a comprehensive review of a client's medication and health history prior, during and after dispensing of prescribed medication(s). The pharmacist conducting a DUR does directly affect the quality of care for clients and outcomes.

TwelveStone Health Partners fosters your safety by:

- Assessing for potential drug interaction
- Drug to Drug
- Drug to food
- Assessing for Allergies/sensitive
- Assessing for side effects
- Common
- Moderate
- Severe
- Conducts Prospective, Concurrent and Retrospective reviews to monitor for
- Health Partners-dispensing activities (cost-effective drug selection)
- Appropriateness of drug therapy
- Effectiveness of drug therapy
- Prevention of potential dangers or adverse events
- Under or over use of drug
- Off-label use
- Box warning

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Problem Solving Procedure

If you have concerns or are not satisfied with services provided you may lodge a complaint without fear of discrimination, reprisal or unreasonable interruption of service:

1. Contact TwelveStone at 1-844-893-0012. We will notify you within five (5) calendar days of receiving your complaint by telephone, email, fax or written letter to confirm that we have received your complaint.
2. Complaints about fees, billing disputes and insurance matters that you feel we did not resolve to your satisfaction, should be directed to your insurance company or Consumer Affairs at 1-800-342-8385.
3. To report abuse, neglect and/or exploitation, call toll free 1-888-APS-TENN (1-888-277-8366).

Notice of Nondiscrimination/Filing a Grievance

TwelveStone complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of politics, social status, race, color, religion, sex, national origin, age or physical or mental disability with regard to access to treatment.

TwelveStone provides free aids and services to people with disabilities to communicate effectively with us, such as written information in large print and free language services to those whose primary language is not English.

If you feel that TwelveStone has failed to provide these services or has discriminated in any other way, you may file a grievance in person, or by mail, phone, fax or emails using the following contact information. Compliance Officer 352 W. Northfield Blvd, Suite 3, Murfreesboro, TN 37129, phone: 615-278-3135, fax: 615-786-7694, email: compliance@12stonehealth.com.

It is unlawful for TwelveStone to retaliate against anyone who opposes discrimination, files a grievance or participates in the investigation of a grievance.

Grievances must be submitted to TwelveStone within 60 days of the date you became aware of possible discriminatory action and must state the problem and the solution sought.

The availability and use of this grievance procedure does not prevent you from pursuing other legal or administrative remedies.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by using any of the following methods:

- Submit electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
- Write to U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201. Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.
- Call 1-800-368-1019 (toll free) or 1-800-537-7697 (TDD).

Patient History Form - ***Page 1 of 2***

Date: _____

TwelveStone Infusion Centers, LLC
Direct Phone: (615) 278-3350
Fax: (615) 278-1923

Please Fax, Email or Print this Assessment and Bring to your Infusion Appointment

PATIENT INFORMATION

First Name:	Middle Initial:	Last Name:	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
_____	_____	_____		

Date of Birth: _____/_____/_____ Patient Lives: ☐ Alone ☐ w/Spouse ☐ w/Family ☐ Nursing Home ☐ Other _____

May we contact you on your home # and leave a message? ☐ Yes ☐ No Occupation: _____

May we contact you on your mobile # and leave a message ? ☐ Yes ☐ No Primary Language: _____

May we contact you on your work # and leave a message ? ☐ Yes ☐ No Will you need an interpreter today? ☐ Yes ☐ No

Are you Employed: ☐ Yes ☐ No If Yes, Employer: _____

Are you a Student: ☐ Yes ☐ No	Alcohol Use: ☐ Yes ☐ No Drinks Per Week: _____	Tobacco Use: ☐ Yes ☐ No Packs Per Day: _____	Drug Use: ☐ Yes ☐ No

Goes by Name: _____ Chief Complaint for Visit Today: _____

Please List ALL Allergies and Reactions: _____

Please List ALL Hospitalizations and Surgeries in the Last 5 years:	Date:

Last TB Screening: _____ Diagnosis: _____

Do you Understand your Plan of Care: ☐ Yes ☐ No
If Yes or No, Please Explain: _____

Pain Level Today (0-10) _____ Location and Duration of Pain: _____

Please List ALL Medications including Dosage and Frequency:

Medication Name	Dose	Frequency	Start Date

Diet: ☐ Regular ☐ Soft ☐ Specialty: _____ Appetite: ☐ Good ☐ Fair ☐ Poor Are you Diabetic: ☐ Yes ☐ No Type: _____

Are You able to Care for Yourself: ☐ Yes ☐ No If No, is your Caregiver willing to Provide Care: ☐ Yes ☐ No Are they Supportive: ☐ Yes ☐ No

Do You feel Safe at Home: ☐ Yes ☐ No Does Anyone Threaten to Harm You: ☐ Yes ☐ No

Functional Limitations:
☐ Amputation ☐ Paralysis ☐ Hearing Loss ☐ Legally Blind ☐ Ambulation ☐ Bowel/Bladder Incontinence ☐ Emotional/Mental ☐ Speech

Assistive Devices: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other _____

Patient Name: _____

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TwelveStone HEALTH PARTNERS

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

General:	**Eyes, Ears, Nose, Throat:**	**Cardiovascular:**	**Psychiatric:**	**Musculoskeletal:**
☐ Fatigue	☐ Recent Changes in Vision	☐ Heart Attack (recent or Past)	☐ Depression	☐ Muscle Pain/Tenderness
☐ Weakness	☐ Eye Pain	☐ Chest Pain or Discomfort	☐ Anxiety	☐ Muscle Weakness
☐ Fever or Chills	☐ Dry Eyes	☐ Shortness of Breath	☐ History of Mental Illness	☐ Joint Swelling/Pain
☐ Trouble Sleeping	☐ Glasses or Contacts	☐ Difficulty Breathing	☐ Panic Attacks	☐ Redness of Joints
☐ Night Sweats	☐ Ear or Hearing Problems	☐ High Blood Pressure	☐ Suicidal Thoughts or Attempts	☐ Arthritis
☐ History of Cancer	☐ Hoarseness	☐ Heart Murmur	**Gastrointestinal:**	☐ Fibromyalgia
Neurological:	☐ Recent Nosebleeds	☐ History of Rheumatic Fever	☐ Nausea or Vomiting	☐ Neck Pain
☐ Head Injury	☐ Sinus Problems or Discharge	☐ Blood Clots	☐ Diarrhea	☐ Back Pain
☐ Recent Falls	☐ Dry Mouth	☐ Swelling in Legs	☐ Constipation	☐ Leg Pain with Walking
☐ Trouble w/Speech	☐ Sores in Mouth	**Dermatologic:**	☐ Change in Bowel Habits	☐ Leg Cramping
☐ Numbness/Tingling	**Genitourinary:**	☐ Skin Cancer	☐ Bloody Stool	**Respiratory:**
☐ Dizziness/Lightheaded	☐ Difficulty Urinating	☐ New Rash or Itching	☐ Fistulas	☐ Asthma
☐ Fainting	☐ Pain or Burning w/Urination	☐ Open Wounds	☐ Ulcers	☐ Wheezing
☐ Seizures	☐ Blood in Urine	☐ Hair or Nail Changes	☐ Abdominal Pain/Bloating	☐ Cough
☐ History of Epilepsy	☐ Frequent Urination/Urgency	**Hematological:**	☐ Reflux	☐ Yellow or Green Mucus
☐ History of Migraines	☐ Incontinence of Urine	☐ Swollen Lymph Nodes/Glands	☐ Hepatitis or Cirrhosis	☐ Coughing Up Blood
☐ Headaches	☐ Kidney Disease	☐ Bleeding Disorder	☐ Incontinence of Stool	☐ Blood Clots in Lungs
☐ Paralysis/Stroke	☐ Discharge from Penis/Vagina	☐ Anemia	☐ Weight Gain or Loss	☐ TB
☐ Lack of Coordination	☐ Genital Rash	☐ Bruises Easily	**Allergy/Immunological:**	☐ Painful Breathing
☐ Tremors			☐ Food or Drug Allergy	
			☐ Seasonal Allergies	
			☐ Recent Fever	
			☐ Hives	
			☐ Exposure to HIV/AIDS	

Females Only: Are you Pregnant: ☐ Yes ☐ No ☐ Maybe

If Yes, How Many Weeks: _____ Are you Breastfeeding: ☐ Yes ☐ No

Males Only: ☐ Frequent Night Urination Number of Times Per Night: _____ ☐ Bladder Problems ☐ Prostate Cancer

PATIENT SIGNATURE

_____ _____
Patient Signature Date

_____ _____
Signature if Patient Unable to Sign Relationship to Patient

_____ _____
TwelveStone Representative Signature Date

IF THERE IS ANYTHING WE CAN DO TO BETTER CARE FOR YOU, PLEASE LET US KNOW.

TWELVESTONE INFUSION CENTERS, LLC
PATIENT CONSENT

1. CONSENT TO INFUSION THERAPY, MEDICAL CARE AND TREATMENT

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, and tests, provided by TwelveStone Infusion Centers, LLC (the "Infusion Center") and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that the Infusion Center and the Clinicians will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if any employee or any individual associated with the Infusion Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.
Prescribed Therapy (Medication):_____ Physician:_____

2. CONSENT TO TREATMENT IN AN OPEN TREATMENT AREA

I acknowledge and understand that the Infusion Center provides infusion therapy and medical care in an open treatment environment. Despite safeguards and using reasonable care, it is always possible in the Infusion Center that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, the Infusion Center expects and requires that its patients maintain strict confidentiality of any inadvertently disclosed health information of others.

3. CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD

I authorize the Infusion Center to photograph, videotape, or record me and agree that the images, video, or recordings may be used for medical reasons (including training, education, or research). I hereby release the Infusion Center, its employees, Clinicians, and other authorized persons from any responsibility which might arise from the taking and authorized use of such images, video, or recordings. **Patient Initials: x_____**

4. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that the Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices.

Use and Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training

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and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

Request for Information from Others. I consent to Infusion Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

5. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Infusion Center's Notice of Privacy Practices, which provides information on how the Infusion Center may use or disclose my health information.

6. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Infusion Center for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

7. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products (e.g. medications) provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered products and non-covered services also may include those products and services the Infusion Center and the Clinicians initially determine to be medically necessary but are later determined unnecessary or denied by my insurance or payer.

8. PERSONAL VALUABLES

I understand that the Infusion Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

Patient Name: _____ Patient Date of Birth: _____
(Print)

Patient Street Address: _____

Patient City/State/Zip: _____

X_____ _____
Patient Signature or Legal Representative Signature Today's Date

If Signed by Legal Representative, Relationship to Patient (e.g. parent, spouse, etc):

_____
(Print Name and Provide Relationship)

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TwelveStone Infusion Center
Patient Satisfaction Survey

Your experience is important to us. In an effort to provide the highest quality Infusion and Injection care, we ask that you complete this questionnaire. Please notify us if our level of care is less than satisfactory. We review each concern and seek resolution to all concerns. We welcome all suggestions from our patients in furthering our quality of care.

Did you speak with a TwelveStone representative about your financial responsibility/out of pocket expense before your appointment was made?	1 2 3 4 5
Were you able to make an appointment in a timely manner?	1 2 3 4 5
Did you receive instructions on how to obtain paperwork for your visit?	1 2 3 4 5
Were the staff helpful and courteous when you arrived for your appointment?	1 2 3 4 5
Were you able to be seated in the Infusion suite within 15 minutes?	1 2 3 4 5
Did you receive a new patient packet upon your visit?	1 2 3 4 5
Did your nurse answer all your questions regarding your infusion or injection?	1 2 3 4 5
Did you have issues with your infusion or injection that was not resolved? If no, please explain.	1 2 3 4 5
Did you feel the staff cared about your health needs while at TwelveStone Infusion Center? If no, please explain.	1 2 3 4 5
Please rate the level of care you received at TwelveStone Infusion Centers.	1 2 3 4 5

Completely Satisfied (5), Satisfied (4), Neutral (3), Dissatisfied (2), and Completely Dissatisfied (1)

- ☐ My Medication was Discussed
- ☐ Side Effects and Possible Adverse Reactions Reviewed
- ☐ Symptoms to Call 911 Discussed
- ☐ Discharge Instructions Reviewed
- ☐ I Understand the Teaching Presented

X_____ _____

Patient Signature or Legal Representative Signature — Date

_____ _____

If Signed by Legal Representative, Print Name — Relationship to Patient

TwelveStone HEALTH PARTNERS

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