PARAGON
PHYSICAL MEDICINE
330-345-4440

Patient Name: _____ Date: _____

1. This practice provides facilities and personnel to assist your physician in the performance of intravenous therapy. You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

a. The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your physician.

b. Alternatives to intravenous therapy is oral supplementation and/or dietary and lifestyle changes.

c. Risks of intravenous therapy include:

i. Discomfort, bruising, and pain at the site of injection.

ii. Inflammation of the vein used for injection, phlebitis.

iii. Severe allergic reaction, anaphylaxis, cardiac arrest, and death.

d. Benefits of intravenous therapy include:

i. Injectables are not affected by stomach or intestinal disease.

ii. Total amount of infusion is available to the tissues.

iii. Nutrients are forced into cells by means of high concentration gradient.

iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

2. You have the right to consent to or refuse and proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures which, in the opinion of your physician, may be indicated.

3. The procedure will be performed by or under the direction of the physician named above with qualified medical assistants.

4. This is a prescription specifically for me and must be used at the frequency ordered or I am at the risk of my prescription expiring and can no longer use. If I do not follow my frequency, I understand that I will NOT receive a refund for unused products.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing.

b. The procedure(s) set forth above has been adequately explained to you by your physician.

c. You have received all the information and explanation you desire concerning the procedure.

d. You authorize and consent to the performance of the procedure(s).

Signature: _____ Date: _____

Paragon Physical Medicine IV Questionnaire:

Name: _____

Phone Number: _____

Date of Birth: _____

Are you currently suffering from any of the following symptoms? Please select all that apply.

- Fever
- Chest Pain
- Vomiting
- Blood in stool
- Shortness of breath
- Diarrhea
- No symptoms

If you checked any of the boxes above, please let a staff member know.

In order to make your future better, we need to know a little about your past…

Do you currently or have you ever been diagnosed with any of the following?

- Coronary Artery Disease
- Heart Arrhythmia (Irregular heart beat)
- Blood Clots of any kind
- Kidney Disease
- Diabetes
- HIV/AIDS
- Liver Disease
- Congestive Heart Failure (CHF)
- Uncontrolled Blood Pressure
- Other
- None

  If chose other, please specify: _____

Current Medications (Please list all current prescription medications you take. TYPE “NONE” If you do not take any prescription medications.

Are you allergic to any medicines or preservatives?

Please list any surgeries you have had in the past:

Do you Smoke?

- Yes
- No

Do you drink alcoholic beverages?

- Yes
- No
- Occasionally

How many drinks per week? _____

Do you exercise?

- Yes
- No
- Occasionally
  How many days per week? _____

Do you drink caffeinated beverages?

- Yes
- No
- Occasionally
- How many per day? _____

- I HAVE INFORMED PARAGON PHYSICAL MEDICINE & MAXIMV'S IV LOUNGE OF ALL CURRENT MEDICATIONS AND SUPPLEMENTS AND AM CURRENTLY NOT UNDER THE INFLUENCE OF ILLEGAL DRUGS OR ALCOHOL.

- THIS IS MY INFORMATION, AND HEALTH HISTORY AND GIVE CONSENT TO PARAGON PHYSICAL MEDICINE & MAXIMV'S IV LOUNGE TO TREAT ME.

Patient Signature: _____ Date: _____

Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc
242 E Milltown Rd, Wooster, OH 44691, (330)345-4440

PATIENT INFORMATION

First Name_____ MI___ Last Name_____ Date_____/_____/_____

Address_____City_____ST_____Zip_____

Home Phone#_____Work#_____Cell#_____

Email_____ Social Security_____

Birth Date_____/_____/_____ Age_____ Gender: Male Female

Family Physician and Clinic: _____

Do we have permission to discuss this case with another family member Y or N Whom: _____
Whom may we thank for referring you to our office_____

Person financially responsible for this account _____

Spouse_____ Your Employer_____

Phone#_____ Phone#_____

Address_____ Address_____

_____ _____

DOB_____SS#_____ Emergency Contact_____

Place of Emp_____ Relation & Phone#_____

Email_____

INSURANCE INFORMATION

Ins. Co. Name_____
Policy#:_____
Group#:_____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's SS#:_____
Insured Add:_____
_____

Employer of Insured:_____

Secondary Ins._____
Policy#:_____
Group#:_____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's SS #:_____
Insured Add:_____
_____

Employer of Insured:_____

Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc
242 East Milltown Rd
Wooster, Ohio 44691
(330) 345-4440

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your Protected Health Information (PHI) in the following ways:

Without your signed authorization
Chiropractic treatment
Payment (cash, insurance, worker's compensation, personal injury)
When release is required by law, including in judicial settings and to health oversight regulatory agency and law enforcement
In emergency situations or to avert serious health/safety situations
To medical examiners, coroner or funeral directors to aid in identifying you or to help them in performing their duties.

Special Cases

To contact you about appointment reminders, treatment alternatives and other health related benefits and services

Other

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights

Restrictions: To request restricted access to all or part of the PHI, write specific information on your patient information and contact our insurance department. We are not required to grant your request.
Confidential Communication: To receive correspondence of confidential information by alternate means or location, contact our insurance or front desk department.
Access: To inspect or receive copies of your PHI, you must sign a consent form.
Amendments: To request changes made to your PHI, contact our insurance department. We are not required to grant your request.
Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request, contact our insurance department.
This Notice: To get updates or reissue of this notice, contact our front desk department.
Complaints: Complaints to Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc or the U.S. Department of Health & Human Services. If you feel your privacy rights have been violated, register your complaint in writing to Dr. Bryce Chaffee. The law forbids us from taking retaliatory action against you if you complain.

Our Duties

We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: For more information about our privacy practices, please contact this clinic at:

PPM/Chaffee Chiropractic Clinic Inc, 242 East Milltown Road, Wooster, Ohio 44691, (330) 345-4440
Effective date: April 14, 2003

I acknowledge receipt of this notice:

_____ _____ _____/_____/_____
_____/_____/____
Patient or Authorized Signature **Printed Name** **DOB** **Date**

If you are signing as the patient's representative:

_____ _____
Patient's Printed Name Relationship to Patient

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Paragon Physical Medicine/CHAFFEE CHIROPRACTIC CLINIC INC, DR BRYCE CHAFFEE, DR TAMI CHAFFEE, CHRISTINA COOK, CNP** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ DOB_____/_____/_____
(patient signature)

X_____
(signature of Guardian if applicable)

X_____
(please print patient name)