INTEGRATIVE HEALTH, INC.
WELLNESS CENTER
EXPERTS PROVIDING NATURAL HEALTHCARE

5191 S Yosemite St, Ste B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

IV Intake - Medical History

Full Name _____ Date of Birth _____

Address _____City, State, Zip _____

Email Address _____

Cell Phone _____ Work Phone _____

Preferred Method of Contact _____

Medical History (circle any that apply):

None
Renal Disease
Seasonal Allergies
Anemia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Benign Prostatic Hypertrophy
Blood Clots
Cancer – Type
Cerebrovascular Accident – Stroke
Coronary Artery Disease
COPD (Emphysema)
Osteoporosis
Seizure Disorder
Crohn's Disease
Depression
Diabetes
Gallbladder Disease
GERD (Gastric Reflux)
Hepatitis C
Hyperlipidemia
Hypertension (High B/P)
Irritable Bowel Disease
Liver Disease
Migraines
Heart Attack
Osteoarthritis
Peptic Ulcer Disease

List any additional History _____

_____

Surgical History (circle any that apply):

None
Appendectomy
Back Surgery
Carpal Tunnel Release
Cholecystectomy (gallbladder removal)
Colostomy
Hernia Repair
Knee Replacement
Liver Biopsy
Small Bowel Resection
Tonsillectomy
TURP
Augmentation Breast
Breast Biopsy
D and C
Mastectomy
Angioplasty w/ Stent
Arthroscopy Knee
CABG (heart bypass)
Cataract Extraction
Colectomy
Gastric Bypass
Hip Replacement
LASIK
Pacemaker
Thyroidectomy
Prostate Biopsy
Vasectomy
Bilateral Tubal Ligation
Cesarean Section
Hysterectomy
Vaginal Hysterectomy

List any additional surgeries _____

Do you smoke and if so how many per day _____
Do you drink and if so how many drinks per week _____

Drug Allergies _____

Medications or Supplements currently taking _____
_____

I certify that information provided to this office is up to date and correct to the best of my knowledge.

Patient Signature _____ Date :_____

Patient Name (Print):_____

Delegate's (RN) Signature _____

Physician's Signature _____

Integrative Health Inc
Experts Providing Healthcare

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_____ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_____ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_____ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_____ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

Cancellation Notice

_____ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

_____

Your Printed Name

_____ _____

Signature Date

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Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

_____

Your Printed Name

_____ _____

Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth: _____

Release of Information

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Name (Print):_____

Witness: _____ Date: _____

INFORMED CONSENT FOR IV THERAPY TREATMENT

Michael Shomaker, MD. 2430 Champa St. Denver, CO 80205

Patient Name _____ Date _____

Service to Performed IV Hydration

Thank you for choosing this independently owned and operated healthcare facility.
We hope you have a good experience here with us today.

Intravenous (IV) Therapy nutrients are infused directly into the bloodstream by a Registered Nurse (RN). The infusion is given very slowly over 20-60 minutes. Normal activities may be resumed immediately after. Procedure may be repeated twice weekly.

Some patients report increased energy levels and improved sense of well-being as a result of IV Therapy. This procedure may be considered unproven by scientific testing and peer reviewed publications and therefore may be considered medically unnecessary or not currently indicated. The patient may suspend or terminate the treatment at any time by informing the RN. Alternatives to injections include oral supplements, capsules, liquid drinks, lotions, topical creams, mouth sprays and preferably nutrient sufficient diet. IV therapy is not intended to correct any nutrient deficiencies. Patients should continue with optimal food choices, with required amounts of vitamins and minerals.

If the IV is administered quickly there may be a sensation of warmth and flushing due to the rapid rise of magnesium. The principal side effects that may accompany intravenous administration include burning and stinging at the site of infusion or if IV infiltrates into surrounding tissue, muscular spasms, weakness or fatigue, fever, headache, rash, itching, skin redness, erythema, pruritus, dizziness, agitation, anxiety, double vision, allergic reactions such as hives and eye swelling, urticaria and edema, (rare), diplopia, and local thrombophlebitis (very rare). Any IV treatment carries a risk of bruising, infection, vein inflammation (phlebitis) and phlebothrombosis (blood clots in vein). A poorly delivered or placed IV needle can lead to complications including hematoma and air embolism. Although very unlikely, there is also a risk that the wrong dose of a nutrient could be infused which could lead to sudden cardiac death.

Risks: I understand there is risk of diarrhea, upset stomach, nausea, a feeling of pain and a warm sensation at the site of injection, a feeling, or sense, of being swollen over the entire body, headache and joint pain. If any of these side effects become severe or troublesome I will contact the healthcare facility immediately.

I understand that although rare, IV Therapy can result in serious, uncommon and dangerous side effects including bloating, constipation, indigestion, heart burn, abnormal bleeding, gastrointestinal hyperactivity, chest pain, flushed face, chills, fever, kidney stones, fingernail weakening, hair loss, rapid heartbeat, heart palpitations, restlessness, muscle cramps, weakness and dizziness.

I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non-prescription medications may result in side effects when they interact with IV Therapy.

I understand the possibility of having an allergic reaction to any of the ingredients found within the IV Therapy is quite plausible and that I should communicate with the nurse if I have any known allergic reactions to foods, dyes, preservatives, medicines or any other substances. If I experience any of the following signs of allergic reactions I should immediately consult my primary health care Physician and discontinue further use of the product. Signs of allergic reactions include, but are not limited to itching of skin, hives, rashes, wheezing, difficulty breathing, swelling of mouth or throat.

When medications are taken in conjunction with IV Therapy nutrients, drug interactions could occur. These interactions can either increase your risk of bleeding or block the absorption of the nutrients into the body. These medications at the time of IV delivery should either be discontinued or be consulted with by a Physician. Some of the medications that may cause drug interactions include, but are not limited to: Heparin (Fragmin, Lovenox, Innohep, etc.), Antithrombin (A Tryn, Thrombate III), Argatroban, Aspirin, Ibuprofen, Dipyridamole (Persantine), Bivalirudin (Angiomax), Clopidogrel (Plavix), Warfarin (Coumadin, Jantoven), non- steroidal anti-inflammatory drugs (Ibuprofen, etc.)

Before starting the Intravenous Therapy, I will make sure to tell the nurse if I have any of the following conditions: Leber's Disease, kidney disease, history of kidney stones, liver disease, hormonal disease, cardiovascular disease, history of ulcers, history of gastrointestinal problems, bipolar disorder, manic depression, Muscular Dystrophy, elliptic seizures, hypoglycemia, schizophrenia, benign prostatic hypertrophy (BPH), acetaminophen poisoning, hypertension (high blood pressure), history of seizures, under-active thyroid (hypothyroidism), an infection, iron deficiency, folic acid deficiency, osteoporosis, receiving treatment or taking any medication that might "thin" the blood, receiving treatment or taking medication that has an effect on bone marrow, attention deficit hyperactivity disorder (ADHD), dependent on intravenous nutrition (TPN) or liquid nutrition products for food, diabetes, mellitus, or high blood sugar levels, an unusual reaction to other medicines, foods, dyes or preservatives

Indications: IV infusion should not be performed on patients who have kidney disease or congestive heart failure. Patients taking digoxin (Lanoxin), potassium-depleting drugs or bortezomib (Velade) should not have this treatment. Patients with allergies to any of the components are not candidates for this treatment. Expectant and lactating mothers are patients where IV Therapy is contraindicated.

Delegation

Michael Shomaker, MD is licensed to practice medicine in the State of Colorado.
He is delegating service to:

Delegate: Tracie McDonald, RN
Phone: 303-416-7090

Clinic: Integrative Health, Inc.
Phone: 303-577-9977
5191 S Yosemite St, Suite B, Greenwood Village, CO 80111

The service the patient is receiving is a medical service; the delegate of the service does not have a medical license in the State of Colorado. The delegate is providing the service pursuant to the delegated authority of the physician.

Acknowledgement

1. I understand the potential benefits of the proposed elective procedure, and alternative treatment options.
2. I understand there are no guarantees from the treatments provided, that in the practice of medicine there are some risks to treatment.
3. I understand more than one procedure may be needed.
4. I have disclosed a full and accurate personal medical history.
5. I have read the above disclosure, and by signing below I give consent to proceed with the medical service.
6. My questions regarding the procedure have been answered satisfactorily by the Registered Nurse.
7. I understand the procedure and accept the possible complications.
8. I hereby release the clinic, registered nurse or any delegate, and medical director from all liabilities associated with the above indicated procedure.
9. I assume full liability for any adverse effects that may arise from non- negligent administration of IV treatment.
10. I agree to allow the medical services to be performed by a delegate of Dr. Michael Shomaker.
11. I understand most insurance companies will not cover this treatment.
12. I understand that if I experience any adverse reactions that I am to call the facility above at the number listed above for expert consultation.

Patient Signature_____ Date_____

Patient Name (Print) : _____

RN Signature_____ Date_____

Patient Name:_____ Service Date:_____

This Page is to be completed by Delegate (Registered Nurse)

Vital Signs	**Begin**	**End**
BP		
Pulse		
Resp		
Temp		
O2 Sat		

Treatment

IV Site _____

Tolerated _____