**ArrIVe Hydration and Wellness**

**Intravenous (IV) Infusion Wellness Therapy**

**Checklist of what to have available:**

* Your completed IV infusion therapy intake form
* A list of all prescription medications, OTC medications, vitamins/supplements that you take
* A copy of your most recent bloodwork, if available, is helpful
* Your signed Consent Form
* Your signed HIPPA Notice
* Make sure you are well hydrated prior to your visit. We suggest drinking 1-2 16oz bottles of water. Dehydration can make it difficult to insert an IV.
* Make sure you eat something prior to your visit. We suggest a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, lightheaded or dizzy.

**During your first visit for IV Wellness Therapy infusions:**

During the first visit, the Practitioner will discuss your main complaints and desired outcomes with you. The provider will review your medical and surgical history and any medications you are taking. Based on this assessment, your intravenous (IV) infusion will be customized to address your individual needs. If you have any complex medical conditions, we at ArrIVe Hydration and Wellness may request you obtain blood work or further testing and/or your personal physician’s approval prior to administering any IV infusions.

**What to expect:**

The IVs used during your intravenous (IV) infusion wellness therapy are exactly the same that you would find at a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful and relaxing setting and leave you feeling revived, relaxed and refreshed.

Depending on your customized IV cocktail, the infusion can be finished in as little as 20-30 minutes. Our attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized and refreshed.

**ArrIVe Hydration and Wellness**

**IV NUTRIENT THERAPY PATIENT INTAKE FORM**

Patient Name: (Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI)\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YY). Age:\_\_\_\_\_\_\_\_\_\_\_ Sex(circle): **M F**

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of Emergency:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your main complaints?** (Please circle all that apply)

Fatigue or low energy Asthma and Allergies

Stress Recent surgical procedures

Poor diet due to busy lifestyle Recent illness

Brain fog or trouble concentrating Cold or flu symptoms

Low mood or depression Facial wrinkles or fine lines

Headaches or migraines Dull or dry skin

Weight gain or difficulty losing weight Malabsorption issues

Pre or Post Menopause Decreased endurance or muscle mass

Slow metabolism Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which statements best describe why you are here today?** (Please check all that apply)

* I want to have more energy and feel better overall
* I want to do everything I can to nourish my body
* I want to everything I can to enhance my weight loss efforts
* I want to prevent getting sick
* I want to recover quickly from my surgery or illness
* I want to slow the aging process
* I want to feel and look younger
* I want to have smoother, brighter and more vibrant skin
* I want to cleanse my body of toxins
* I want to recover quickly from a hangover
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Are you pregnant or breastfeeding? YES / NO

Date of last chemistry screen or other lab testing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(please check all that apply)

* Hypermagnesemia (high magnesium levels)
* Hypercalcemia (high calcium levels)
* Hypokalemia (low potassium levels)
* Hemochromatosis (high iron levels)
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a diabetic? *YES / NO* Controlled? *Medications / Diet* Glucometer? *YES / NO*

Are you a smoker? *YES / NO* eCigs? *YES / NO* How much and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many alcoholic drinks do you consume in a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel or ever been told that you may drink too often or too much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any recreational drugs? YES / NO

If Yes, which ones and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list everything you are currently taking:**

Prescription Medications – Over the counter supplements – strength- frequency- condition being treated

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Name and DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY CONTINUED**

Do you take Digoxin (Lanoxin) for a heart problem? YES / NO

Do you take any diuretics or water pills? YES / NO If yes please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any steroids, ie: prednisone? YES / NO If yes please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medication or food allergies? YES / NO If yes please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any vitamins or herbals? YES / NO If yes please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following conditions? (Please check all that apply)

* Blood pressure problems (high or low)
* Heart problems
* Stroke or “mini stroke”
* Kidney problems
* Kidney stones
* Liver problems
* Asthma
* Sickle Cell Anemia
* G6PD Deficiency
* Sarcoidosis
* Parathyroid problems (high levels)
* Sulfa allergy
* Allergy to sesame oil, grapeseed oil, or lidocaine

List any other medical conditions you have (not mentioned above)

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List of all surgical procedures you’ve had or are having with approximate dates

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Is there anything else you would like your providers to know?

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HIPPA NOTICE OF PRIVACY PRACTICES

At ArrIVe Hydration and Wellness, we understand that health information about you is very personal, and we are mandated by the Heath Insurance Portability and Accountability Act (HIPPA) to protecting your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us, and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

**We are required by law to:**

* Make sure that health information that identifies you is kept private
* Give you this Notice of our legal duties and privacy practices with respect to health information about you
* Follow the terms of the Notice that is currently in effect

**How we may use and disclose health information about you:**

* For treatment
* For payment
* For healthcare operations
* For appointment reminders
* As required by law
* As required by the Military or Veterans and Workers Compensation
* Coroners, health examiners and funeral directors
* National Security and Intelligence activities
* Protective Services for the President and others
* Security Officials for Inmates
* Public health risks
* Health oversight activities
* Lawsuits and disputes
* Law enforcement
* To avert a serious threat to health and safety

**Your rights regarding Health Information about you:**

* Right to inspect and copy
* Right to amend
* Right to Accounting of Disclosures
* Right to Request Restrictions
* Right to Request Confidential Communication

**Your Medical Records:**  The original copy of your paper and/or electronic medical record is the property of ArrIVe Hydration and Wellness. You may request a copy of your records to be transferred by completing a medical records release form. We require 14 business days from the date of your request to prepare and send your records unless the records are for urgent or life-threatening health issues. (See medical release form below.)

**Changes to this Notice:** We reserve the right to change this Notice. We will post a copy of the current notice in our binder or facility with the current effective date.

**Complaints:**  If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator where you were treated to file a complaint. For complete, detailed information regarding privacy law, visit [www.cms.gov/hipaa](http://www.cms.gov/hipaa)

Permission to Share your Health information: We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.

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Acknowledgement of Receipt of the ArrIVe Hydration and Wellness HIPAA NOTICE OF PRIVACY PRACTICES:

We request that you sign this form acknowledging you have received, read, and reviewed the HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient. This acknowledgement will become part of your records.

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Printed name of patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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