Third Circle Medical
Cenchrea Lanier, MSN, ANP-BC,
1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

www.ThirdCircleMedical.com

Staff use only
VS: _____
BP: _____/_____
HR: _____
Resp: _____
02 Sats: _____
Infusion name:_____
Injection:_____

Date: _____

Name: _____ DOB:_____ Age: _____ Social Security_____

Address:
_____City_____St_____Zip_____

Phone: _____Email: _____

Reason for visit: _____ Height: _____ Weight: _____

Emergency Contact: _____ Phone:_____

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better? _____
_____

Allergies (Medications, foods, etc.):
_____
_____

Current Medications: (Please include OTC & supplements)
_____
_____

Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

☐High Blood Pressure ☐ Asthma
☐Heart Murmur ☐ COPD
☐Valve Disorder ☐ Sleep Apnea
☐ Abnormal Rhythm ☐ Shortness of Breath
☐ Chest Pain ☐ Pulmonary Hypertension
☐ Heart Attack ☐ Lung Cancer
☐ Cardiac Surgery or Stents ☐ Other Lung Disorder _____
☐ Congestive Heart Failure ☐ Other Cardiac Disorder _____
☐ Peripheral Artery Disease
☐ Thrombosis or DVT
☐Aneurysm

GASTROINTESTINAL AND URINARY

☐ Acid Reflux ☐ Liver Disease
☐ Bladder Disease ☐ Hepatitis A, B, C
☐ Kidney Disease ☐ Other _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

☐ Hyper/Hypo Thyroid ☐ Rheumatoid Arthritis
☐ Diabetes Type I Type II ☐ Hx of DKA
☐ Lupus ☐ Other _____

NEUROLOGIC
☐ Stroke/TIA ☐ Parkinson's
☐ Multiple Sclerosis ☐ Alzheimer's
☐ Seizures – date of last seizure _____

HEMATOLOGY
☐ Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
☐ MTHFR
☐ G6PD Deficiency

MUSCULOSKELETAL
☐ Back Pain ☐Degenerative Joint Disease
☐ Carpal Tunnel Syndrome ☐Degenerative Disk Disease
☐ Fibromyalgia ☐Other_____

PSYCHOLOGICAL
☐ Depression
☐ Anxiety or Panic Attacks
☐ Suicidal Ideations

CANCER
☐ Location of cancer _____
☐ Chemotherapy
☐ Radiation

WOMEN (non-menopausal)
☐ Last Menstrual Period _____ Any chance that you are pregnant? _____
☐ Are you currently breastfeeding? _____

PAIN
☐ CRPS
☐ Fibromyalgia

Do you drink alcohol or abuse any types of drugs? If so, please explain:
_____
_____

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?
_____
_____

Would you like to tell us anything else that you feel like is important?
_____
_____

I attest that the information I have provided is true and accurate to the best of my knowledge:

_____
Signature Date

_____
Print name

Third Circle Medical
Cenchrea Lanier, MSN, ANP-BC,
1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

IV Infusion and Injection Consent Form

This form outlines that you understand that a peripheral intravenous catheter will be inserted into a vein in your body, and you will have fluids, vitamins, minerals, nutrient, and/or medications infused directly into your body. This is considered "IV Infusion Therapy." If you are having injection therapy, then you understand that a vitamin, mineral, nutritional compound, and/or medication will be injected directly into the subcutaneous fat or muscle of your body. This is considered "Injection Therapy."

Please read each point below and acknowledge by signing, that you agree:

1. I understand that IV infusion and/or injection therapy at Third Circle Medical, LLC is not intended to diagnose or treat a specific medical condition. I understand that I am here seeking IV infusion and/or injection therapy voluntarily to assist with certain symptoms or ailments I may be experience.

2. I have informed Third Circle Medical, LLC, Cenchrea Lanier and Medical Staff of all the medications, supplements, and allergies that I have. I understand that serious adverse events could happen if I do not disclose all of my drug/food/vitamin/and additional allergies and medications/supplements that I am currently taking.

3. I understand that the procedure involves inserting a needle into a vein or having a solution injected into my muscle or body fat.

Risks

Common risks involved with IV and/or injection therapies include, but are not limited to, irritation, pain, discomfort, bruising, and bleeding at the site of the IV insertion or injection. Less common risks involved with IV and/or injection therapies include, but are not limited to, infection at the site of the IV insertion or injection, injury to the tissue, phlebitis, low blood pressure, fainting, fluid volume overload, medication interactions, and drops in blood sugar levels. I understand that *rare* side risks involved with IV and/or injection therapies include, but are not limited to, sepsis, severe allergic reactions, severe medication/supplement interactions, anaphylaxis, blood clots, shock, cardiac arrest, and death.

Benefits

The benefits of IV and injection therapies include, but are not limited to, enhanced absorption of vitamins and minerals as they bypass the digestive tract, increased total body hydration, alleviation of certain symptoms, increased total body nutrient density, and improved performance/recovery.

I affirm that I am voluntarily seeking IV infusion and injection therapies at Third Circle Medical, LLC and have not been coerced into doing so.

I understand the risks and benefits of the procedure, IV infusion therapy, and injection therapy and have had all my questions answered to my full satisfaction.

I understand that I have the right refuse any treatments or treatment recommendations at any time.

Voluntary Nature of Treatment and Alternative Therapies

Treatment with IV and injection vitamins/hydration/nutritional/mineral and/or medications offered at Third Circle Medical, LLC is completely voluntary in nature and that I am seeking out this therapy on my own or from the recommendation of my referring provider. Alternative therapy for the symptoms you are seeking IV infusion and/or injection therapy for include, not are not limited to, ongoing treatment by your primary care provider and/or specialty provider, oral supplementation, and dietary/lifestyle modifications.

Signature _____ Date_____

Final patient consent for treatment.

- I acknowledge that I have been given sufficient information about IV hydration/vitamin/mineral/nutrient infusion and injection therapy and all its associated risks and benefits upon which to make an informed decision about treatment.
- I acknowledge that there are no guarantees regarding the results of treatment and its effect on my presenting condition.
- I certify that I am of sound mind and body to make medical decisions and to consent for treatment.
- I certify I will continue to remain under the care a licensed and qualified primary care provider and/or mental health provider as IV infusion and injection therapy is considered an adjunctive and non-medically necessary treatment option, not a complete one.
- I release Cenchrea Lanier at Third Circle Medical, LLC and all the medical staff from all liabilities for any complications or damages associated with IV infusion and/or injection therapy.
- I have read this consent and fully understand the information within it and I voluntarily authorize and consent to the treatment options, including but not limited to IV infusion therapy, provided to me at Third Circle Medical, LLC.

Signature _____ Date_____

Third Circle Medical
Cenchrea Lanier, MSN, ANP-BC,
1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

Dear Patient,

You are being provided this letter of acknowledgment because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay cash discount". A self-pay cash discount is offered to patients who elect to pay for the service in full on the date of service and who ***will not be submitting the claim to an insurance carrier***. You have requested that this service be coded as self-pay cash discount because **(initial one):**

____ You have **no** health insurance
____ You have health insurance but you will **not** be billed and instead want to pay out of pocket.
____ Cosmetic Procedure (Botox, Sclerotherapy, PRP Facial, PRP Injections)
____ Other Service (includes IV Wellness Infusions)
____ Other (please explain):
_____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay cash discount service must be paid on the date of service.
- The self-pay cash discount amount covers only the professional services provided by your provider. You are financially responsible for all ancillary services, for example: laboratory, x-ray, or other services at Third Circle Medical not performed by your provider. You will receive a separate bill from the ancillary services.
- If you have insurance or other types of coverage, services today that are included in the "self-pay" cash discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay cash discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Patient Signature _____ Date: _____

If signed by someone other than the patient, please specify relationship to the patient:
_____

Signature: _____ ID#_____ Date: _____ Time: _____

NOT PART OF THE LEGAL MEDICAL RECORD