Third Circle Medical
PATIENT REGISTRATION FORM

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Last name:	**First:**	**Middle:**	**Marital status:**

Is this your legal name?	If not, what is your legal name?	Former name:	**Birth date:**	**Age**:	**Sex:**
☒ Yes ☐ No					☐ M ☐ F

Address:	**City:**	**State:**	**Zip:**

Social Security no.:	**Home phone no.:**	**Cell phone no.:**
Your Email:	**Your Employer:**	**Employer phone no.:**

Chose clinic because/referred to clinic by (Please choose one option):

☒ [Doctor's name]

☐ Friend

IN CASE OF EMERGENCY WHO WOULD YOU LIKE US TO CONTACT :

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient or Guardian Signature

Date

Third Circle Medical
MEDICAL HISTORY INFORMATION SHEET

NAME: _____ AGE: _____ TODAY'S DATE: _____

DATE OF BIRTH: (m/d/y) _____/_____/_____ HEIGHT: _____ ft _____ inches WEIGHT: _____ lbs

REASON FOR TODAY'S EXAM: _____

HISTORY:

Past Surgical History: Surgery	Date	Past Medical History: Condition	Date

HISTORY OF SERIOUS INJURIES OR ILLNESSES: ☐ YES ☐ NO If yes, please describe: _____

_____

COVID Vaccine: ☐ YES ☐ NO If yes, which one: _____ Booster**:** ☐ YES ☐ NO

Family History: (check all that apply and relationship to patient)

☐ Heart Attack_____ ☐ Cancer _____ ☐ Colon Problems _____☐ Diabetes _____

☐ Blood Pressure _____ ☐ Other: _____

☐ None

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children How Many? _____

Tobacco Use: ☐ Never ☐ In the Past ☐ Currently: Type? _____ How much? _____ How long? _____

Alcohol Use: ☐ Daily ☐ Occasional ☐ Never Other substance use or abuse? ☐ Yes ☐ No Type: _____

Do you have allergies? ☐ Yes ☐ No ☐ Food ☐ Drug ☐ Latex ☐ Other: _____

ALLERGEN	REACTION

Medications: List of Medications (including over-the-counter medications)

(If you have list, we can make a copy)

Medications	Dosage	Frequency

Your Pharmacy Name and Address: _____

Intravenous High-Dose Vitamin C (HDVC)

INFORMED CONSENT:

I, _____ (DOB: ____/____/_____) consent to treatment with Intravenous High-Dose Vitamin C (HDVC) provided by Third Circle Medical.

As I have indicated a desire to undergo high-dose intravenous treatment with ascorbic acid (Vitamin C), the method of administration, the mechanisms of action, the purposes for its administration in my particular case; its potential for benefit, and its potential for harmful side effects have been fully explained to me by the medical staff at Third Circle Medical by verbal and written documentation. It is now my purpose to stipulate my full and complete understanding with reference to therapy, and to remove any legal liability on the part of the physician and Third Circle Medical staff in the event this treatment is unsuccessful.

I have been advised that high-dose Vitamin C used intravenously is not a standard, FDA-approved treatment for cancer or other serious illnesses. I have been made aware that high-dose Vitamin C is being used increasingly by a group of physicians for the treatment of cancer under the following circumstances: As adjunctive therapy alongside proven, conventional treatments; in cases with no known, effective treatments; in cases of treatment failure using proven methods. I am also aware that published research is available showing that high-dose intravenous Vitamin C therapy has been effective in a relatively small, select number of cancer cases, including advanced cancers, although it is considered experimental and not “usual” or “customary” in these particular circumstances.

I have been informed that Medicare and most insurance companies will not pay for this “non-covered service” as they continue to view it as experimental. Because of this, I understand that I am responsible for payment for this treatment at the time services are rendered. I also agree that I have been informed of the approximate costs of this form of treatment. Whether or not high-dose IV vitamin C is “safe”, “effective”, “customary”, or “reasonable” for a specific condition depends upon the inherent possibility of injury from the procedure when properly administered, upon the prognosis for the medical condition if left untreated, and upon making the appropriate changes in lifestyle, diet, and supplementation as directed by the medical staff of Third Circle Medical. It is believed that in my specific case, high-dose IV vitamin C is proper under these criteria and that its use could possibly improve the condition for which I am under treatment, s well as my overall health.

However, I do understand that no one can or does guarantee the results in any manner. I agree that I have been given the opportunity to ask questions, and that I am either already aware of have been advised of the more traditional forms of treatment for my particular condition,. I am also aware that I may seek a second opinion from other physicians or alternative practitioners and have either already done so or decline to do so, and that I have arrived at my decision to utilize high-dose IV vitamin C of my own free will.

I understand the possible side effects of high-dose vitamin C may include lowering of blood sugar and may become symptomatic in people with blood sugar problems such as diabetics.
Mild, but self-limited headaches after infusions have also been reported on occasion.

Individuals with a relatively rare condition called Glucose-6-Phosphate Dehydrogenase Deficiency could have a more severe reaction involving hemolysis or rupture of their red blood cells requiring transfusion or hospitalization. To prevent this reaction, our protocol mandates that every patient receiving a series of high-dose IV vitamin C infusions undergo y could have a more severe reaction involving hemolysis or rupture of their red blood cells requiring transfusion or hospitalization. To prevent this reaction, our protocol mandates that every patient receiving a series of high-dose IV vitamin C infusions undergo screening for this genetic anomaly. Individuals with other risks for kidney stones may be at further increased risk for this with high dose vitamin C.
Conditions predisposing a patient to kidney stones are screened for prior to initiating treatment and every attempt is made to minimize risk in this situation. Other more mild side effects of complication that can occur with this type of

treatment include, but are not limited to, local infection, inflammation or bruising at the site of insertion of the catheter or needle.

Finally, because this is considered an experimental therapy/treatment, other as yet unforeseen medically related problems could arise. Although, widespread uses of high dose IV vitamin C around the country by Integrative providers , has generally shown this to be a very safe therapy, Third Circle Medical cannot offer this procedure to you without the condition that you release Third Circle Medical and its providers and staff from any legal responsibility for harm resulting from the use of high-dose IV vitamin C and your signature on this informed consent will constitute a full and final release of our medical-legal responsibility resulting from the administration of high-dose intravenous vitamin C.

Patient Signature: _____ Date: _____

Physician 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, HDVC)
____ 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