Welcome to Citrus Infusion & Injection Center!

Locally Rooted. Patient Focused.

Dear Patient,

Welcome to Citrus Infusion & Injection Center, where our mission is to bring compassionate, high-quality care home to Citrus County. We are honored you've chosen us to provide your prescribed infusion or injection therapy. We understand how difficult it can be to manage a chronic condition—especially when access to treatment requires long drives and added stress. That's why we're here: to deliver expert care, right where you live.

What to Expect:

1. We coordinate with your referring provider to gather all necessary documentation and transfer your care smoothly to our center.
2. Once your insurance benefits and any required prior authorizations are secured, we'll contact you by phone to schedule your first appointment.
3. We assist with procuring financial access, including manufacturer copay assistance programs, and foundation financial support when available. If you're already enrolled in one, please let us know.
4. Prior to your infusion or injection appointment, we'll confirm your insurance, collect your medical history, and walk you through every detail of your treatment.
5. Before your infusion or injection begins, our skilled clinical team will explain your therapy, answer your questions, and ensure your comfort.

If you have questions at any point in your care, you can always reach us directly:

(352) 503-2442

info@citrusinfusioninjection.com

www.citrusinfusioninjection.com

Our Commitment to You:

We are proud to serve the residents of Citrus County and surrounding communities in a private, relaxed, and professional environment. Our center was built with your needs in mind—offering both the clinical excellence you expect and the hometown care you deserve.

At Citrus, you'll enjoy:

- Private infusion suites
- Comfortable recliners and space for a guest
- Flat screen TVs with streaming options
- Complimentary snacks and WiFi

- Appointments available Monday–Friday, 8AM–7PM (by appointment), Saturday 9am – 2pm, Sunday 9:00am-2pm (by appointment)
- Friendly, licensed staff who know your name—and your story

We Value Your Feedback

Your experience matters. Here are a few ways you can share your thoughts or concerns with us:

6. Patient Survey: You'll receive a confidential survey after your visit to tell us how we did.
7. Direct Feedback: Speak with any staff member at the center at any time.
8. Grievance Process: You may submit a grievance form, and our leadership team will respond within 48 hours.
9. Contact Information: You can also reach us at (352) 503-2442 or via our website's contact form.

If you wish to file a formal concern with an external body, you may also contact:
• Medicare: 1-800-MEDICARE
• Accreditation Commission for Health Care (ACHC): (919) 785-1214

Thank You for Choosing Citrus

We know that receiving infusion or injection therapy is a significant part of your health journey—and we are here to make that journey easier. Thank you for trusting Citrus Infusion & Injection Center with your care. If you'd like a tour of our facility or have questions before your visit, don't hesitate to reach out.

Warm regards,
The Citrus Infusion & Injection Center Team
Locally Owned. Community Driven. Compassionately Delivered.

Citrus Infusion & Injection Center

Patient Demographics and Medical History Form

Patient Demographics

Patient: Last Name: _____ First: _____ MI: _____

DOB (MM/DD/YYYY):_____ SSN: _____-_____-_____ Sex (M/F): _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Mobile Phone:_____ Email:_____

Occupation:_____

Employer:_____

How did you hear about us? _____

If you answer Yes to any of the following, we would like to discuss further how we may best support your needs:

- Do you experience any challenges with hearing or vision that we should be aware of? ☐ Yes ☐ No
- Are there any cultural or religious preferences you would like us to consider in your care? ☐ Yes ☐ No
- Would you prefer to speak or receive information in a language other than English? ☐ Yes ☐ No
- Do you have an Advance Directive you would like us to keep on file? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Insurance Information:

Policy Holder Name: _____ Policy Holder DOB: __/__/____

Primary Insurance: _____ Secondary Insurance: _____

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Medical History

Have you been diagnosed with a chronic illness or condition? ☐ Yes ☐ No

If yes, please list:

Have you had any past surgeries? ☐ Yes ☐ No

If yes, please list along with date:

Surgery	**Date**

Treatment Reason

What is the current underlying medical condition and the medication that you are seeking an injection or infusion treatment for?

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Do you have a current medical condition/diagnosis other than what you are seeking treatment from us today?

Please list your current physician/s:

Medication History

Is this your first time receiving this medication? ☐ Yes ☐ No

How long have you been receiving treatment with this infusion/injection medication? _____

Do you pre-medicate before your infusion/injection? ☐ Yes ☐ No

If Yes, what medications do you take:

- ☐ Tylenol Dose: _____
- ☐ Benadryl Dose: _____
- ☐ Solumedrol Dose: _____
- ☐ Claritin Dose: _____
- ☐ Ibuprofen Dose: _____
- ☐ Other Dose: _____

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Have you ever experienced any problems or adverse reactions to your infusion/injection? ☐ Yes ☐ No

If Yes, please describe in detail:

Current Medications

Please list all medications you are currently taking:

Medication	Strength	Dosing

Allergies

Please list all allergies (medication or non-medication related):

Social History

Do you currently smoke? ☐ Yes ☐ No

If yes, how many cigarettes per day? _____

Did you quit smoking? ☐ Yes ☐ No

If yes, when did you quit? _____

Do you currently drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per day? _____

Did you quit drinking? ☐ Yes ☐ No

If yes, when did you quit? _____

Do you currently use illicit drugs or marijuana? ☐ Yes ☐ No

If yes, what substances and how often?

Attestation:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Citrus Infusion & Injection Center. I understand that I am financially responsible for any balance that remains after insurance and/or if my insurance denies any claims. I also authorize Citrus Infusion & Injection Center or my insurance company to release any information required to process my claims.

_____ _____

Signature of Patient or Legal Guardian (required) Date

CITRUS INFUSION & INJECTION CENTER

906 Eden Drive | Inverness, FL 34452

T: (352) 503-2442 | F: (352) 503-2443

www.citrusinfusioninjection.com

PATIENT CONSENT FOR TREATMENT FORM

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, subcutaneous injections, intramuscular injections and tests provided by Citrus Infusion & Injection Center and its associates, physicians, providers, nurses, and clinicians (collectively referred to as "Clinicians"). of vitamins, mineral therapy, nutrition therapy or prescription medication as prescribed to myself, or my dependent. I understand that in many instances the Clinicians are carrying out orders from my referring health care provider(s). Although I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they relate to my health, Citrus Infusion & Injection Center and the Clinicians will not be responsible for any injuries or damages that may result from my non-compliance. I have been informed of the nature, purpose, and possible risks of the treatment I will receive and agree to proceed with such treatment. I acknowledge that I received this informed consent document at the time of check-in and have had the opportunity to ask questions.

PREGNANCY AND BREASTFEEDING CONSENT (Biological Female Patients)

☐ I am not pregnant and do not suspect that I am. I am aware of the potential risks to an unborn fetus should I become pregnant while undergoing treatment. If I become pregnant during treatment, I will notify Citrus Infusion & Injection Center Clinicians immediately.

☐ I am pregnant but will continue treatment. I have discussed this with my healthcare provider and understand the potential risks to the fetus.

☐ I am breastfeeding but will continue treatment. I have discussed this with my healthcare provider and understand the potential risks to the infant.

HEPATITIS B VIRUS CONSENT

I understand that if any employee or individual associated with Citrus Infusion & Injection Center is exposed to my blood or body fluids, I will be tested for Hepatitis viruses and Human Immunodeficiency Virus (HIV). I understand I will receive education related to this testing and will not be charged for the testing and related education.

If I have not received the Hepatitis B Virus (HBV) vaccine, or should I refuse the vaccine, I understand that due to my exposure to potentially infectious material, I may be at risk of contracting HBV, which can be potentially life-threatening.

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EMERGENCY CARE CONSENT

In the event of a medical emergency while on site, I authorize the staff to initiate emergency medical treatment and, if necessary, arrange for transport to a local emergency facility.

ACKNOWLEDGMENT OF ALTERNATIVE TREATMENT OPTIONS

I understand that my referring provider has informed me of potential alternative treatments or therapies available and I have voluntarily chosen to proceed with the recommended course of treatment.

RIGHT TO WITHDRAW CONSENT

I understand that I have the right to decline or discontinue treatment at any time. I will notify the clinical team of my decision and understand the risks of doing so.

CONTACT FOR RESULTS OR FOLLOW-UP

I authorize the staff to contact me regarding treatment plans, results, or follow-up using the preferred methods I have indicated in my registration form (phone, voicemail, email, text, etc.).

MEDICATION DISCLOSURE RESPONSIBILITY

I agree to inform the clinical team of all current medications, supplements, and allergies to ensure safe administration of therapy.

BEHAVIOR AND CONDUCT EXPECTATIONS

I agree to treat all staff and patients with respect and understand that disruptive or abusive behavior may result in termination of services.

CONSENT FOR MINORS (IF APPLICABLE)

If the patient is a minor, I attest that I am the legal guardian and authorized to provide consent for medical care.

CONSENT TO PHOTOGRAPH, VIDEOTAPE, OR RECORD

I authorize Citrus Infusion & Injection Center to photograph, videotape, or record me and agree that these materials may be used for medical reasons including treatment, education, and research. I release Citrus Infusion & Injection Center and its employees from any responsibility related to the authorized use of these images, video, or recordings.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Citrus Infusion & Injection Center's HIPAA Notice of Privacy Practices, which outlines how my personal health information may be used or disclosed. By signing below, I acknowledge that I have read and understand the HIPAA and OSHA policies presented to me at the time of check-in.

I understand that during my visit at Citrus Infusion & Injection Center, I may be exposed to Protected Health Information (PHI) and that all such information is confidential. I agree not to interfere with patient care and to follow staff instructions if asked to leave a patient care area.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment of all insurance and health care benefits directly to Citrus Infusion & Injection Center for services rendered. I understand that benefits may be payable to me if I do not provide this authorization.

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FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for charges not paid by my insurance provider. This includes any medications, services, or products provided to me that are not eligible for insurance reimbursement, including those determined to be non-covered or unnecessary by my insurance provider.

PERSONAL PROPERTY

I understand that Citrus Infusion & Injection Center is not responsible for any lost, stolen, or damaged personal belongings while I am on the premises.

PATIENT SIGNATURE AND DATE

Patient Signature: _____ Today's Date: _____

Citrus Infusion & Injection Center

Medical Records Release Authorization Form

By signing this form, I authorize the release of confidential health information about me to or from Citrus Infusion & Injection Center. This may include a copy of my medical records or a summary/narrative of my protected health information.

Patient's Name: _____

Patient's Social Security Number (last 4 digits): _____

Patient's Date of Birth: ___ / ___ / _____

Release Records From:

Name/Facility: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Send Records To:

Citrus Infusion & Injection Center
906 Eden Drive
Inverness, FL 34453
Phone: (352) 503-2442 Fax: (352) 503-2443
www.citrusinfusioninjection.com

Use of Information:

Release of Health Records. I understand that the Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I understand that any/all information contained in my health records is property of the Infusion Center.

Use and Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

Request for Information from Others. I consent to Infusion Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

Authorization:

This authorization applies to all health care information related to my treatment plan. This may include chart notes, test results, demographics, insurance, and my most recent medical history and physical examination.

This authorization shall remain valid for one year from the date of signature unless otherwise specified or revoked in writing. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

I authorize and request the prompt release of my medical records as specified above.

Patient Signature and Date

Patient Signature: _____ Date: _____ / _____ / _____

CITRUS INFUSION AND INJECTION CENTER

Patient Communication Consent Form

I, _____the undersigned, give permission to the staff of Citrus Infusion and Injection Center, including clinical, administrative, and billing personnel, to communicate with me and my healthcare providers (such as my referring physician, nurse practitioner, or specialist) through email, text message, or telephone regarding matters related to my care. This may include medical updates, test results, appointment scheduling, prescription information, and billing matters.

I understand and agree to the following terms regarding digital communication:

- Citrus Infusion and Injection Center staff may choose to stop communicating with me electronically at any time for any reason.
- I will not use email or text messaging to report emergencies or urgent medical issues. In such cases, I will seek appropriate emergency medical attention or dial 911.
- Citrus Infusion and Injection Center may set policies or conditions for the use of email or text communication. These may change over time.
- My email or text messages may be used to update my medical records or may be accessed by authorized individuals involved in my treatment or billing.
- Citrus Infusion and Injection Center does not guarantee timely responses to messages and recommends that I follow up if I have not received a response in a reasonable time.
- The Center and its staff will not be held responsible for any harm or inconvenience resulting from email or text communication, including delayed responses or miscommunication.
- If I change my email address or phone number, I will notify Citrus Infusion and Injection Center immediately.
- I may revoke this consent at any time by submitting a written request and ensuring it is received by the appropriate staff.

I acknowledge that electronic communications carry privacy risks, including the potential for messages to be intercepted, misdirected, or accessed by unauthorized individuals. I understand that messages relating to my care may become part of my permanent medical record.

In the case of an emergency or time-sensitive issue, I understand I should not rely on email or text messages and instead should contact emergency services or visit the nearest emergency department.

By signing below, I confirm that I have read and understood the terms of this Communication Consent Form and voluntarily agree to the outlined terms.

PATIENT SIGNATURE AND DATE

Patient Name (Print): _____

Patient Signature: _____

Date: _____

CITRUS INFUSION & INJECTION CENTER

906 Eden Drive | Inverness, FL 34452

T: (352) 503-2442 | F: (352) 503-2443

www.citrusinfusioninjection.com

PATIENT NOTICE OF FINANCIAL RESPONSIBILITY

Personal Financial Responsibility

I hereby authorize and give my consent for Citrus Infusion & Injection Center to file any and all claims to my health insurance carrier(s). I understand that my insurance policy is a contract between myself and my insurance company, and that payment to Citrus Infusion & Injection Center is ultimately my responsibility. I recognize that certain services provided may not be covered by my specific insurance plan. If my insurance denies coverage for services rendered, I understand that I am responsible for payment at the time of service.

If I do not have health insurance or choose not to use it, I agree to pay in full prior to receiving any services. Certain offerings may be designated as 'Self-Pay' and must also be paid in advance.

No Show / Cancellation Policy

We schedule appointments to serve our patients as efficiently as possible. Missed appointments and last-minute cancellations prevent others from accessing timely care. A 'no show' is defined as missing a scheduled appointment without notice. A 'late cancellation' is canceling within 24 hours of the scheduled time.

While we understand that emergencies may arise, repeated failure to attend or cancel appropriately may incur fees:
- No-show fee: $100
- Late cancellation: $50 to $100 depending on treatment type, due to the cost of prepared medication.

Exceptional situations will be reviewed on a case-by-case basis.

Patient Insurance Responsibility

I consent to Citrus Infusion & Injection Center releasing necessary medical records to my insurance provider for purposes of treatment, payment, and healthcare operations, including provider credentialing and quality reviews. I understand that my medical information will remain confidential and that I may revoke this consent in writing at any time. Any disclosures made prior to revocation are authorized by this agreement.

I acknowledge that payment is due at the time of service unless alternative arrangements are made in advance. If the clinic is billing my insurance, I agree to pay all co-pays, coinsurance, or deductibles at the time of my visit. Insurance benefits are not guaranteed and are determined during claims processing. I accept full responsibility for any charges denied by my insurance.

Furthermore, I am responsible for promptly notifying Citrus Infusion & Injection Center of any changes to my insurance coverage. Failure to do so may result in claim denials, for which I am fully financially responsible.

Payment Plans and Financial Assistance

Citrus Infusion & Injection Center is committed to minimizing the financial burden on our patients. We make every effort to offer flexible payment plans for copayments, deductibles, and other out-of-pocket costs. Our team will work with you to develop a manageable payment schedule based on your financial needs.

In addition, we actively assist in the coordination and processing of copay assistance programs provided by pharmaceutical manufacturers. We also pursue funding opportunities from charitable foundations and grant programs to help reduce patient costs wherever possible. Our goal is to ensure that finances do not become a barrier to receiving necessary treatment. Please note that some services or treatments may be classified as cash-pay only and are not eligible for insurance billing. In such cases, full payment will be required in advance before treatment can be administered.

Patient Signature: _____ Date: _____

Citrus
INFUSION & INJECTION CENTER

Citrus Infusion and Injection Center, Inc.

906 Eden Drive
Inverness, FL 34452
www.citrusinfusioninjection.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say “yes” to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Citrus
INFUSION & INJECTION CENTER

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 05.25.25