

Vitamin Infusion Welcome Packet

Bloom Health and Wellness Center of Kansas City welcomes you as a new vitamin-infusion patient to our medical clinic. We look forward to working with you as partners in your care.

Enclosed you will find several forms for your review prior to your appointment. Specifically, enclosed are the following:

- **Vitamin-Infusion General Information**
- **Patient’s Electronic Communications Authorization and Consent Form**
- **Patient’s Medical History Form**

At your appointment, you will also receive additional forms, including a Medical Informed Consent, and a copy of our office’s privacy practices.

Please read and review the attached forms prior to your consultation, so that you are ready to ask questions about the process and your health.

Submitting Your Information

Once you have completed the following pages, you will have several options. You may **Save** the file to your desktop computer, from which you can email it back to Bloom Health & Wellness ([email to: ketamine@bloomhealthkc.com](mailto:ketamine@bloomhealthkc.com)); **Clear** all the form fields, should you need to redo any section; or use the **Print** button (which requires you to have access to a home or office printer) to print a hardcopy of the forms to bring to your appointment. You may also fax the completed forms to us at 913-232-8032.

If you forget to complete or submit these necessary forms prior to your appointment, you may be asked to fill them out again in our office before your consultation.

Vitamin-Infusion General Information

What are Vitamins and Minerals?

Vitamins and minerals are essential substances that our bodies need to develop and function normally. The known vitamins include A, C, D, E, and K, and the B vitamins: thiamin (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxal (B6), cobalamin (B12), biotin, and folate/folic acid. A number of minerals are also essential for optimal health: calcium, phosphorus, potassium, sodium, chloride, magnesium, iron, zinc, iodine, sulfur, cobalt, copper, fluoride, manganese, and selenium.

Multivitamins/multiminerals (MVMs) are the most frequently used dietary supplements, but MVMs cannot take the place of eating a variety of foods that are important to a healthy diet. However, some people who don't get enough vitamins and minerals from food alone, or who have certain medical conditions, might benefit from taking these vitamins and minerals in an IV form.

Do I Qualify for Vitamin Infusions?

From the outset, please know that only persons that pass our medical screening procedure are eligible to receive vitamin infusions. Certain medical conditions, including, but not limited to, high blood pressure, renal failure or congestive heart failure, may exclude you from eligibility because of the risk from receiving the fluids associated with the vitamin infusions.

For those that do qualify, infusions are effective because the delivery mechanism bypasses your gastrointestinal tract and introduces the vitamins and minerals directly into your bloodstream. As a result, your body rapidly rebalances its total fluids, helping to restore your energy and optimize your well-being.

If I Qualify, What Happens Next?

After Bloom Health has determined that you are eligible to receive vitamin infusion therapy, you may begin the treatment.

How do I Pay for Vitamin Infusions?

Bloom Health and Wellness of Kansas City is not contracted with insurance companies, and does not file any claims for service. Therefore, payment is "out of pocket."

If you wish to pursue reimbursement from your insurers, Bloom Health will provide receipts for your service so that you may pursue any potential reimbursement. Bloom Health does not investigate reimbursement policies by any health insurer.

Payment must be rendered prior to treatment, and may be made by cash, credit card, and HSA (health savings account). The cost of each vitamin infusion is listed on our website.

How Do I Get Started?

Please use our website to arrange your appointment, or call the office at the number below.

Next, please print out these forms and review them carefully. At the appointment, you and the treating physician will review your medical and psychiatric history to determine if you are eligible for treatment, review and discuss other important forms, such as the Patient's Informed Medical Consent, and discuss any questions you may have.

What Should I Expect?

The IVs used during the Intravenous (IV) infusion therapy are exactly the same that you would find in a hospital. Our infusions are given in a peaceful setting and should leave you feeling calm, relaxed, and refreshed. All of our infusions last from 45-240 min. Our experienced and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing, and the goal is to leave feeling vibrant, energized, and refreshed.

Once your treatment is completed, the nursing staff will review with you the post vitamin infusion instructions and answer any further questions. You will also be provided a written copy of the discharge instructions at the end of your visit to help you remember how to optimize your vitamin infusion experience and maintain the health benefits and effects as long as possible.

VITAMIN INFUSIONS – WELCOME

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Does Bloom Health Accept Emergencies?

No. If you are having an emergency of any type, call 911 and go to your nearest Emergency Department. Bloom Health does not provide Emergency Services. If you are having thoughts of suicide, please call the National Suicide Prevention Lifeline at 800-273-8255.

Does Bloom Health Offer Prescriptions?

No. Bloom Health and Wellness Center of Kansas City does not provide prescriptions and does not provide refills on medications from other physicians.

What is Bloom Health's Termination Policy?

In some cases, it may be necessary to terminate the physician-patient relationship and forgo any further treatments by Bloom Health and Wellness Center. Termination may occur at any time and may be initiated by either the physician or the patient. Reasons for termination by the physician may include, but are not limited to, non-compliance with treatment, disruption of facility operations, verbal or physical abuse of the staff, or any violation of the discharge instructions.

VITAMIN INFUSIONS – WELCOME

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Electronic Communications Authorization

I hereby authorize Bloom Health and Wellness of Kansas City, LLC (“Bloom Health” hereinafter) to communicate with me using electronic communications including but not limited to email, text messages, voicemail, and video conferencing meetings. I authorize Bloom Health to contact me solely by the telephone numbers, addresses, and information that I have provided to Bloom Health during any part of our contact. These communications may include appointment information and reminders, protected health and confidential information. I understand that these electronic communications are not encrypted and that Bloom Health is not responsible for the privacy of such communications once they have been transmitted to the numbers provided by me.

LAST NAME FIRST NAME

TODAY'S DATE (MM/DD/YYYY)

By selecting this check box, I consent to receive information from Bloom Health & Wellness through electronic correspondence.

VITAMIN INFUSIONS – PATIENT HISTORY

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LAST NAME FIRST PREFERRED D.O.B

ADDRESS CITY STATE ZIP

SEX: MALE FEMALE PHONE EMAIL

EMERGENCY CONTACT NAME EMERGENCY CONTACT PHONE

HOW DID YOU LEARN ABOUT BLOOM HEALTH & WELLNESS:

Internet Facebook Friend/Relative Walk-in Other:

WHAT ARE YOUR MAIN COMPLAINTS? (CHECK ALL THAT APPLY)

Fatigue or low energy Difficulty concentrating Facial wrinkles or fine lines Other:
 Stress Low mood or depression Dull or dry skin
 Poor diet/busy lifestyle Cold/Flu symptoms Malabsorption issues

WHICH STATEMENTS BEST DESCRIBE WHY YOU ARE HERE TODAY? (CHECK ALL THAT APPLY)

I want to have more energy and feel better overall I want to prevent getting sick
 I want to do everything I can to nourish my body I want to recover quickly from surgery or illness
 I want to do everything I can to enhance my weight loss efforts I want to look/feel younger
 I want to learn about way I can improve longevity I want to have smoother, brighter more vibrant skin
 I want some education about healthy nutrition I want to cleanse my body of toxins
 I want to prevent or treat dehydration Other:

YOUR PAST MEDICAL HISTORY INCLUDES: (CHECK ALL THAT APPLY)

Acid Reflux Blood Clots Gallstones HIV/AIDS Osteoporosis
 Alcohol/Drug Abuse Cancer (Specify below) Glaucoma Irritable Bowel Skin Infections
 Allergy Problems Cataracts Gout Kidney Disease Recurrent UTI
 Anemia Chronic Pain Headaches Kidney Stones Seizures
 Artery/Vein Issues Colitis/Crohns Heart Disease Liver Issues/Hepatitis STDs
 Arthritis Depression, Anxiety Heart Valve Issues Lung Disease Sleep Apnea
 Asthma Diabetes Hernia Mental Health Issues Stroke
 Autoimmune Disease Esophagitis/Ulcers High Blood Pressure Migraines Thyroid Diseases
 Bleeding Problems Fractures High Cholesterol MRSA Tuberculosis (TB)

Other diseases or ailments:

Hospitalization/Serious injuries:

VITAMIN INFUSIONS – PATIENT HISTORY

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YOUR PAST SURGICAL PROCEDURE HISTORY: (CHECK ALL THAT APPLY)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Angioplasty (Balloon) | <input type="checkbox"/> Dental Surgery | <input type="checkbox"/> Hysterectomy, Partial | <input type="checkbox"/> Stents |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Arteries | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Tonsils and/or Adenoids |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Blood Vessel Surgery | <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Veins |
| <input type="checkbox"/> Colon/Rectal Surgery | <input type="checkbox"/> Hysterectomy, Complete | <input type="checkbox"/> Sinus Surgery | |

Other surgeries not listed above:

Previous adverse reaction to anesthesia (please explain):

MEDICATION LIST:

Please list all prescription and non-prescription medications you are currently taking including dosages. This may include vitamins, herbal medicine, supplements, birth control pills, inhalers, and over the counter medications.

DISCONTINUED MEDICATION LIST:

List all medications you have stopped taking in the last 12 months

ALLERGIES OR REACTIONS:

List all including allergies to medications, food, and environments

FAMILY HISTORY OF DISEASE (CHECK ALL THAT APPLY)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Addiction Problems | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | |

Form Continues on Next Page

VITAMIN INFUSIONS – PATIENT HISTORY

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SOCIAL HISTORY:

WHICH BEST DESCRIBES YOUR CURRENT LIVING SITUATION? (CHECK ALL THAT APPLY)

Alone Spouse/Partner Child/Children Close Relative Other:

WHOM DO YOU RELY ON FOR BASIC SUPPORT AND HELP?

CIGARETTE/NICOTINE USE:

Current Smoker Never Smoked Former Smoker If former, when did you quit? How many packs/day?

IF YOU SMOKE, ARE YOU INTERESTED IN QUITTING? YES NO

OTHER NICOTINE USE? YES NO DO YOU USE A VAPING DEVICE? YES NO

ARE YOU EXPOSED TO SECOND HAND SMOKE? YES NO

ALCOHOL CONSUMPTION: (CHECK ALL THAT APPLY)

I don't drink alcohol I sometimes drink alcohol I frequently drink alcohol

Beer Wine Liquor How many drinks per week?

CAFFEINATED BEVERAGE CONSUMPTION: (CHECK ALL THAT APPLY)

I don't drink caffeine Coffee Tea Soda Energy Supplements How many drinks per week?

RECREATIONAL DRUG USE:

YES NO If yes, please list:

DO YOU EXERCISE REGULARLY:

YES NO If yes, how many days per week? Type of exercise:

HOW MANY HOURS OF SLEEP DO YOU GET PER NIGHT: DO YOU WAKE IN THE MORNING FEELING RESTED: YES NO

FEMALE PATIENTS ONLY:

Date of your last menstrual period: Have you gone through menopause? YES NO

Number of pregnancies: Number of live births: Current birth control method:

By selecting this check box, I attest that the above personal health information is correct and complete to the best of my knowledge.

TODAY'S DATE: (MM/DD/YEAR)

SAVE FORM

CLEAR FORM

PRINT FORM

Patient Confirmation

I attest that the information I have provided to Bloom Health and Wellness Center of Kansas City in the Patient History form is true and correct. And, if applicable, I have made any and all updates before executing this page.

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE

TODAY'S DATE (MM/DD/YYYY)
