Palmetto INFUSION

Consent for Treatment, Assignment of Benefits and Release of Information

Patient Name		**Employer Name**	**MRN**
Mailing Address		Employer Address	**Responsible Party Name**
City / State / Zip		City / State / Zip	Relationship
Date of Birth		Employer Phone	Date of Birth
Patient SSN			SSN
Home Phone	Cell	**Emergency Contact**	Address
Email Address		Relationship	City / State / Zip
Sex Male ☐ Female ☐		Phone	Phone
Have you applied for Social Security Disability? ☐ Yes ☐ No		When?	Status of application: Approved ☐ Denied ☐ Pending ☐
I would like to consult with a pharmacist about the prescribed medication therapy.			**Yes** ☐ **No** ☐

Consent for Treatment

I authorize Palmetto Infusion to administer infusion therapy in the ambulatory infusion or home setting. My physician has instructed me on the prescribed therapy, and I understand why the medication is necessary, its risks, advantages, possible complications and alternatives. I also understand that in any medication therapy there are risks both known as well as unknown; I further understand that any complications, injuries or adverse results cannot be given the immediate medical attention in the ambulatory site or in the home, as in the hospital setting. I have discussed these matters with my physician and my signature below indicates my willingness to undergo infusion therapy provided by Palmetto Infusion. In the event of a staff blood exposure/needle stick, I agree to have my blood drawn.

Statement To Permit Payment Of Medicare Benefits To Provider

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services or its intermediary any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to Palmetto Infusion as provider furnishing services".

Agreement to Pay

Palmetto Infusion Services has agreed to supply patient with any supplies and services ordered by patient or on behalf of patient, the undersigned patient or responsible party agree that each of them is responsible for payment for all such supplies and services provided patient. Balances released to our attorney or collection agency for non-payment may incur additional fees, which will also be the responsibility of the patient or responsible party. Patient is responsible to pay co-pay/co-insurance at the time of service.

Assignment of Benefits

Assignment of Benefits The undersigned hereby authorizes Palmetto Infusion to request on my/our behalf and to collect directly all public and private insurance coverage benefits or patient assistance funds due for supplies and services supplied by PIS. In the event payments for insurance benefits or patient assistance funds are made directly to any of the undersigned, the payee will endorse to Palmetto Infusion all checks for such payments.

Release of Information

The undersigned hereby authorizes our insurer(s) and any other third party payor who provides patient with coverage to disclose to Palmetto Infusion, any information regarding such coverage, including but not limited to 1) payments made by such insurer(s) or third party payor(s) to any of us, for infusion therapy rendered to patient by Palmetto Infusion and 2) the scope and extent of coverage available from time to time. I also authorize all medical personnel to provide information to Palmetto Infusion concerning patient/client medical history, as it may relate to patient/client therapy. The undersigned consents to the review of patient/client records including medical records by any Federal, State, or Accrediting Body or Agency as required by the Regulatory, Licensing or Accrediting body.

Notice of Privacy Practices

I acknowledge I have received the Palmetto Infusion notice of privacy in full as contained in the patient information booklet. This booklet also contains the patient rights and responsibilities and I am responsible to read the information provided. The undersigned certifies that he/she has read the foregoing and received a copy, as well as a copy of the patient rights and responsibilities documented above. The undersigned also certifies that he/she is the patient or is duly authorized by the patient as patient's general agent to execute and accept its items.

Patient's Signature_____Date_____

Responsible Party's Signature_____ Date_____

If this form is not signed by patient, please explain. Reason: _____