Lumicera® Infusion Services

CONSENT, ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION AGREEMENT

Patient Name _____ **Patient Account No** _____

Patient Address _____

Equipment Rental ☐

As the patient, or personal representative, I agree and understand that infusion equipment (as listed in delivery ticket) such as infusion pumps, has been provided to me on a rental/loan basis. It must be returned to the pharmacy at completion of therapy or as requested for maintenance. I understand and agree I will be financially responsible for any damaged or unreturned equipment not to exceed $3000 per piece of equipment. Initials: _____

Acknowledgement of Financial Responsibility

As the patient or personal representative, I agree and understand that infusion therapy has been ordered for me. I am responsible for payment for all supplies and services provided. I have been informed of and agree to payment of all deductibles, co-pays, spend down amounts and any remaining balance for services provided to me. In the case of no insurance coverage, or retroactive termination of benefits, I agree to be responsible for payment of all services provided to me.

Acknowledgement of Receipt of Information

As the patient or personal representative, I acknowledge that I have received and understand the information in the Welcome Kit patient handbook. The Welcome Kit contains the following information:

1. Welcome Letter
2. HIPAA Notice of Privacy Practices
3. Refill and Shipping Reference
4. Medication and Sharps Disposal
5. Non-Discrimination Notice
6. Patient Bill of Rights
7. Patient FAQs
8. Patient Rights and Responsibilities
9. Emergency Disaster Plan
10. Home Safety Information
11. Infection Control Instructions
12. Notice of Privacy Practices
13. Pain Management Information
14. How To File A Complaint
15. Advance Directives Information
16. Medication Information Sheets

I would like to consult with a pharmacist about my medication therapy: ☐ Yes ☐ No Initials: _____

Assignment of Benefits

As the patient or personal representative, I authorize Lumicera Health Services to submit a claim on my/our behalf to insurance (which shall mean and include, Medicare, Medigap, any commercial insurance or pharmacy benefit manager) for the supplies and services provided to me related to infusion therapy. I assign my insurance benefits to Lumicera Health Services for supplies and services provided to me and request authorized insurance payments be made to Lumicera Health Services. In the event payments are made directly to the patient or responsible party, they will be endorsed to or paid by the patient or responsible party to Lumicera Health Services.

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Consent to Home/Ambulatory Site of Therapy

As the undersigned patient or personal representative, I have been advised of and understand the benefits and risks of home/alternate site infusion therapy. I understand that the emergency medical attention that is provided in a hospital cannot be rendered in the home/alternate site setting. I understand that there are risks associated with any drug therapy that are both known and unknown and agree to notify my provider of any adverse reaction or other significant health related events. I understand that an HIV test may be performed on me without my consent if a health care provider is exposed to my bodily fluids or blood. I have discussed the prescribed therapy with my health care provider and have indicated willingness to receive home/alternate site infusion therapy. I agree to remain in the care of my prescriber throughout the course of therapy. Lastly, I hereby authorize Lumicera Health Services to provide infusion services and consent to receive the therapy as prescribed. 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.

The undersigned also certifies that he/she is the patient or is duly authorized by the patient as patient's personal representative to execute and accept its items.

NOTE: A duplicate copy of this Agreement and Consent shall be considered the same as the original.

Patient Signature _____ Date _____

Personal Representative Signature _____ Date _____

Personal Representative Relationship _____

Witness _____ Date _____