**Infusion Care**

**PATIENT AUTHORIZATION AND PLAN OF SERVICE**

Patient Name: ID

**Insurance payment authorization**: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to Infusion Care for pharmaceuticals / products / services that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

**Release of insurance information**: I request my medical insurance plan(s) to release to the above-named facility, any and all information which will assist in processing my claims for pharmaceuticals / products / services that I am receiving from the above-named facility even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company, or the above-named facility any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals / products / services that I have received, rather than directly to the above-named facility, I agree to endorse those checks and send them immediately to the above-named facility.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Infusion Care financial hardship program.

**(Initials) I acknowledge that I have been advised of my financial responsibility to Infusion Care.**

**Patients who have been set up with Copay Assistance for their specialty infusion or biologic medication must notify Infusion Care if they receive a bill/statement for that specialty medication. Failure to report the bill/statement will result in the patient being responsible for the total of the bill. Additionally, failure to report any insurance changes to our office will result in the patient being responsible for what insurance does not cover.**

**(Initials) I acknowledge that I have been advised of my financial responsibility to Infusion Care.**

Our office policy is to put medical evaluation and treatment on hold for any patient who has an outstanding balance of $250.00 or greater. If this occurs and the bill is not paid in a timely manner, then the patient’s information will be sent to The Collections Agency to collect and can have long-term effects on their credit.

I hereby agree that Infusion Care or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the pharmaceuticals / products / services provided. I have received the pharmaceuticals / products / services ordered. I have received a copy of a patient handout that contains: Patient Bill of Rights and Responsibilities, HIPAA Privacy Notice, Emergency Planning, Home Safety, Infection Control, Making Decisions about Your Health Care, and Grievance / Complaint Reporting.

I have received facility marketing material and information on the facility’s **scope** of services. I have received instructions on how to follow up with Infusion Care

I understand that Imay lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (334) 521-0073 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this facility by calling Medicare at 1-800-MEDICARE and/or the Accreditation Commission for Health Care (ACHC) at (919) 785-1214.

**Identified needs/problems:** The patient may be unfamiliar with use of the pharmaceuticals / products / services provided. Expected outcomes: The patient will be provided the pharmaceuticals / products / services to comply with the physician’s prescription. The patient will know how to obtain follow-up services as needed.

PRINT NAME:

PATIENT OR RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

PATIENT OR RESPONSIBLE PARTY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF BENEFICIARY IS UNABLE TO SIGN:**

**WITNESS SIGNATURE / RELATIONSHIP:**

**REASON PATIENT UNABLE TO SIGN:**

Form Revised: 12/15/2022