Infusion Care of East Alabama
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 of East Alabama 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 of East Alabama financial hardship program.

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

Patients who have been set up with Copay Assistance for their specialty infusion or biologic medication must notify Infusion Care of East Alabama 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 of East Alabama.**

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 collection agency to collect and can have long-term effects on their credit.

I hereby agree that **Infusion Care of East Alabama** 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 of East Alabama.

I understand that I may 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 of 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 the 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: 06/2024

New Patient Registration(Please Print Clearly)

Infusion Care of East Alabama

Patient Information

Last Name_____**First Name**_____**Middle Initial** _____ **Preferred**_____

Address_____**City**_____ **State**_____ **Zip**_____

Home # _____ **Work #** _____ **Cell #** _____

Date of Birth _____ **Social Security #**_____

Email Address_____@_____ **Preferred Method to Contact You:** _____

Gender Assigned @ Birth __ Male __ Female __Other **Gender Identity** __ Male __ Female __Other

Race ___African American/Black ___Asian ___Caucasian/White ___Native Hawaiian/Pacific Islander ___Decline

Ethnicity __Hispanic/Latino ___ Not Hispanic/Latino ___ Decline **Language** ___ English ___ Spanish ___ Other: _____

Mark All That Apply ___ Student @ School Name _____ ___ Retired ___ Disabled

___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Employer_____ **Work #** _____

Primary Care Doctor _____ **Who referred you?**_____

Preferred Pharmacy and Address _____

Responsible Party Information *(Please leave this section blank if you are responsible for yourself.)*

Last Name_____**First Name**_____**Middle Initial** _____ **Preferred**_____

Address_____**City**_____ **State**_____ **Zip**_____

Home # _____ **Work #** _____ **Cell #** _____

Date of Birth _____ **Social Security #**_____

Email Address_____@_____ **Relationship to Patient** _____

Employer_____ Occupation_____

Emergency Contact

Name _____ **Relationship to Patient** _____

Phone # 1 _____ **Phone # 2** _____

Insurance Information

Is your visit with us related to a work injury or illness? __ Yes __ No

If Medicare, please check one __Still working or Spouse has Employer Group Health Plan __ Disabled Beneficiary under 65 Years of Age

Primary Insurance Company **(We will need a copy of the front and back of your insurance card.)**

Subscriber Name _____ **Relationship to Patient** _____

Date of Birth _____ **Social Security #**_____

Policy/Member#_____ **Group #** _____

Employer/Place of Work _____

Secondary Insurance Company **(We will need a copy of the front and back of your insurance card.)**

Primary Insurance Company **(We will need a copy of the front and back of your insurance card.)**

Subscriber Name _____ **Relationship to Patient** _____

Date of Birth _____ **Social Security #**_____

Policy/Member#_____ **Group #** _____

Employer/Place of Work _____

Patient Personal & Family Medical History

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Height: _____ Weight: _____

Hospitalizations: ☐ None

Please include the year of hospitalization.

_____

_____

_____

_____

Surgical History: ☐ None

Please include the year of surgical procedure.

_____

_____

_____

_____

_____

Current Medications: ☐ None

☐ **List Provided**

Please include as needed medications.

_____

_____

_____

_____

_____

_____

Drug Allergies: ☐ None

_____

_____

_____

_____

_____

Personal / Social History:

Are you currently Pregnant? **YES** **NO**

Are you currently Breast feeding? **YES** **NO**

Do you smoke? **YES** **NO**

How many years ?_____

How many packs per day?_____

When did you quit?_____

Exposed to cigarette smoke? **YES** **NO**

Do you drink alcohol? **YES** **NO**

How many drinks per week?_____

Do you use recreational drugs? **YES** **NO**

Please check all that apply:

Asthma	
Eczema(Atopic Dermatitis)	
Food Allergy	
Drug Allergy	
Insect Allergy	
Hives	
Autoimmune Disorder	
Pneumonia	
Migraine	
Meningitis	
Thyroid	
Diabetes	
Glaucoma	
High Blood Pressure	
Cancer	
Stroke	
Heart Disease	
Bleeding Disorder	
Heartburn or Reflux	
Hepatitis (Liver)	
Kidney Disease	
Arthritis	
Epilepsy/Seizures	
Anxiety	
Depression	
HIV(OPTIONAL)	

Patient Consent Form

Today's Date_____

Patient Name: _____

Date of Birth: _____

Infusion Care of East Alabama

_____**(Initials)** I have read and understand the **OFFICE POLICIES AND PATIENT RESPONSIBILITIES** and agree to all terms and conditions set forth herein.

_____**(Initials)** I have received the ***Notice of Privacy Practice*** from Infusion Care of East Alabama. I understand that I may request a copy of the Notice by asking the receptionist. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices* and to make changes regarding all protected health information under the control of this practice.

_____**(Initials)** **Evaluation and Treatment**. I consent to diagnostic procedures and medical care as deemed necessary in the judgment of my Physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. However, I understand that my Physician will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____**(Initials)** **Pharmacy Benefit Management (PBM).** Electronic Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Medication History Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, you agree that Infusion Care of East Alabama can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

_____**(Initials)** **Advanced Beneficiary Notice of Non-Covered Services (ABN/NNS).** As your physician and healthcare team, we/I want to provide you with the best possible care. There may be certain routine services/procedures performed during your visit(s), such as but not limited to; breathing test, patch testing, skin testing, food challenges, drug challenges, and/ or other test that we/I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. These tests will only be ordered if deemed necessary to your treatment and care. Anything non-covered by your insurance contract you will be responsible for the total cost. Copayment, co-insurance, and deductibles may apply.

_____**(Initials)** **Government Compliance**. In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Infusion Care of East Alabama must inform you that there are other options pertaining to infusion and pharmacy services. Specifically, it should be noted that you have presented to Allergy Asthma & Immunology Specialists voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the clinician may determine that infusion and/or pharmacy services may be needed. Allergy Asthma & Immunology Specialist and Medicus Specialty Pharmacy offers many of these services as a convenience to our patients. If any patient would like to have their infusion and pharmacy services provided at another location, we can provide you with a list of nearby locations which are available within a 25-mile radius. If I have no preference in providers, Asthma Allergy & Immunology Specialists and/or Medicus Specialty Pharmacy will be utilized. I am aware Infusion Care of East Alabama has an interest in those businesses. I authorize Infusion Care of East Alabama to release the necessary information concerning my case history, treatment, and examination for my visit to the above-named businesses.

_____**(Initials)** **Billing and Collections Policy.** We strive to provide exceptional care to all our patients, but we also must ensure financial sustainability. Patients are responsible for timely payment of co-payments, deductibles, and outstanding balances. If an account becomes past due and our efforts to collect payment are unsuccessful, then your account will be turned over to a Collection's Agency. Please note that accounts sent to the Collection Agency will incur **an additional 20% fee** on the outstanding balance to cover the collection costs. We encourage patients facing financial difficulties to contact our billing department for assistance with payment options as we are committed to finding reasonable payment solutions.

_____**(Initials)** **Medical Data Exchange.** Medical data may be exchanged through networks facilitated by the Interoperability Hub, such as Carequality and CommonWell. This enables seamless sharing of your health information among authorized healthcare providers for improved coordination and continuity of care.

[ ] Opt-In: I **do** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents

[ ] Opt-Out: I **do not** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents.

By signing below, I hereby agree and understand the Office Policies and Patient Responsibilities, Notice of Privacy Practice, Evaluation and Treatment, PBM, ABN/NNS, Government Compliance, Billing Collections Policy, and Medical Data Exchange:

Signed:_____ **Print:** _____ **Date:** ____/____/____

Patient

Signed:_____ **Print:** _____ **Date:** ____/____/____

Guardian

Guardian's Relationship to Patient: _____

Consent to Disclose
Medical Information Authorization

Today's Date_____

Patient Name: _____

Address: _____

_____

Date of Birth: _____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy rules.
3. I understand that I may revoke this authorization at any time by notifying our office in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the renovation, and Infusion Care of East Alabama will not be liable for any PHI released prior to me revoking this authorization.
4. I understand that by leaving spaces blank I am indicating that I do not want any medical information released to anyone else.
5. I understand that this authorization will expire: _____. ***(if no date this authorization will expire after 1 year)***

Disclose Information to the following:

(List any doctors or individuals you would like to have access to your information.)

Name:_____ Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

Guardian Information for Minors: ***(if guardians are not listed below, they will not have authorization to your medical records)***

Guardian Name:_____ Guardian Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

By signing below, I hereby authorize Infusion Care of East Alabama to release any or all my medical records to the following individuals, physicians, or companies:

Signed:_____ **Print:** _____ **Date:** _____/_____/_____
Patient

Signed:_____ **Print:** _____ **Date:** _____/_____/_____
Guardian

Guardian's Relationship to Patient:_____

Infusion Care
of East Alabama

WELCOME PACKET

At Infusion Care of East Alabama, our mission is to be the area's leading caregiver for patients with allergies, chronic respiratory problems, and immune system deficiencies. We provide care for individuals of all ages.

WEBSITE: www.InfusionCare.org
EMAIL: Admin@InfusionCare.org

Publication Date: 01/2025

OFFICE POLICIES AND PATIENT RESPONSIBILITIES WELCOME PACKET

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES:

We believe that all patients receiving services from Infusion Care of East Alabama should be informed of their rights.

Therefore, you are entitled to:

- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of service.
- Be informed of your financial responsibilities in advance of the service / care being provided. Medicare beneficiaries will be informed if the assignment is not accepted.
- Receive information about the scope of services that the organization will provide and specific limitations on those services.
- Participate in the development and periodic revision of the plan of service.
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented.
- Be informed of patient rights under state law to formulate an Advanced Directive, if applicable
- Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality.
- Be able to identify visiting personnel members through proper identification.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.
- Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal.
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated.
- Confidentiality and privacy of all information contained in the patient record and of Protected Health Information
- Be advised on the facility's policies and procedures regarding the disclosure of clinical records.
- Choose a health care provider, including choosing an attending physician, if applicable
- Receive appropriate care without discrimination in accordance with physician orders, if applicable
- Be informed of any financial benefits when referred to an organization.
- Be fully informed of one's responsibilities.
- Patients submit forms that are necessary to receive services.
- Patient provides accurate medical and contact information and any changes.
- Patient consents to evaluation and treatment for services provided by the facility.
- Patient notifies the facility of any concerns about the care or services provided.

INSURANCE BILLED AND FEES

Your health insurance policy is a contract between you and your health insurance company. Infusion Care of East Alabama is not a party to that contract. Our relationship is with you, not your insurance company. If you have any questions regarding whether a particular service is covered, please check with your insurance company first. **As a courtesy to you, we file claims directly with your insurance company. We are affiliated with the most common insurance companies.** If your insurance company is not listed on our website, then please ask if we are able to file claims with your insurance before services are rendered.

Deductibles, co-payments, and co-insurance are required by your health insurance company and were agreed upon by you when you accepted their insurance contract. Infusion Care of East Alabama must contract with insurance companies agreeing to collect such deductibles, co-payments, and co-insurance in order to participate with their insurance plan. Co-payments and co-insurance must be collected at the time services are rendered. **There will be a $15 fee if we must bill you for the co-payment or co-insurance if not paid on the day of service.**

Your insurance company will send you a report (Explanation of Benefits or a Processed Claim Report) showing what we charged, what they adjusted per contracted rate, and what they paid on your behalf. This is not a bill or statement from Infusion Care of East. We receive a similar document and must process this information, review the claim, and re-file the claim if needed. As a result, statements to you from Infusion Care of East Alabama are often delayed two months or longer as we attempt to collect from your insurance company. If your insurance company has not paid Infusion Care of East Alabama the submitted charges within 90 days, then you will be responsible for the full amount charged and you will need to pursue direct reimbursement from your insurance company.

If your insurance requires you to be seen by your primary care physician before being referred to Infusion Care of East Alabama, then it is your responsibility to have this done in advance. With such plans, your primary care provider must generate all referrals for any specialist, ER visit, x- ray study or outpatient procedure. If not, then the claim will be denied by your insurance plan and the charges will be your responsibility. Additionally, for such plans, if a specialist recommends another doctor or test, you must still get the referral from your primary care doctor or the claim will be denied, and the cost will be your responsibility. Referrals must be made before a visit; however backdated referrals may be made in emergent situations as defined by your plan and regulations posted by your primary care physician.

As our patient, we want to provide you with the best care possible. Often, we need to diagnose conditions by testing, such as skin testing for allergies or lab tests for hives and treat conditions using medications and shots. We consider these diagnostic and treatment protocols as standard of care and medically necessary.
Unfortunately, there are insurance plans that have a $200 cap per year on what they will pay for when it comes to allergy testing and treatment, or they may simply refuse to pay for a procedure or treatment that they may deem medically unnecessary. It is essentially impossible for us to know which insurance plans maintain such policies. Rather, it is you, the card holder, who is responsible for being aware of your insurance company's coverage policies. All charges are your responsibility whether your insurance covers them. If allergy shots are not covered by your insurance company, then you may discuss with our billing department a payment plan.

Please keep in mind that most insurance companies require you to meet your deductible before your coverage begins. It is essentially impossible for us to know what your deductible is, which varies from zero to thousands of dollars depending on your insurance type.

SELF-PAY

Self-pay patients must pay for services in full at the time services are rendered. Payment plans are not available for office visits. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect that amount from the other parent. If you have an unpaid balance over 60 days, you will be required to pay your balance in full before being seen in our office.

RETURNED PAYMENT

There is a $30.00 fee for a returned check or any payment from you that does not clear properly for any reason. This fee offsets the fee charged by our bank, as established by law. This fee is in addition to the payment that was being made by the returned check. We reserve the right to contact the District Attorney's Worthless Check Unit or others for assistance in collecting these payments pursuant to Section 12A-9-13.2 of the Code of Alabama and Section 13-6-15 of the O.C.G.A.

MEDICAL RECORDS/FMLA/LETTERS

If your records must be sent to another doctor or organization, then a signed written request is required and a copying fee of $1.00 per page for the first 25 pages and $0.50 per page thereafter will be due in full. The Medical Records Release Form, which is a HIPAA requirement, is available at our office and on our website at EAAllergy.com.

A receipt for a co-payment or co-insurance payment will be provided to you on the day of service only. If a receipt is requested at a later day, there will be a $1 charge per receipt.

Any credit or refund due to you will be applied toward future charges by Infusion Care of East. If there are no charges in the subsequent 12-month period, then you may receive the credit or refund by contacting our billing department.

The following are fees that must be paid before the paperwork will be released to the patient:

- FMLA - $25.00
- Detailed Letter / Statement / Form - $20.00
- A $5.00 fee will be charged if the paperwork / form needs to be expedited (5 business days)

ACCOUNT BALANCE

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.

CANCELLATION AND NO-SHOW POLICIES

It is the policy of Infusion Care of East Alabama that patients need to report for their scheduled appointments. In the case that a patient is unable to make the scheduled appointment, the patient must give 24-hour advanced notice to the front office staff by calling (334) 521-0073, otherwise your chart will be marked as a No-Show for that visit. In the event of 24-hour notice not being given, then the following fees are applied: $50 for a missed office visit or up to $50 for missed scheduled procedure. You will be notified of such fee, which will be due prior to the next scheduled appointment.

TERMINATION POLICY

Infusion Care of East Alabama reserves the right to terminate our relationship with the patient if:

- Three (3) or more appointments are missed consecutively.
- Three (3) or more appointments are missed in a twelve (12) month period.
- The patient does not follow the appropriate guidelines of therapy as directed by the physician(s), including but not limited to asthma controller medications and allergy shots.
- The patient's or the patient's caregivers' behavior and/or actions are offensive to Infusion Care of East Alabama or Infusion Care of East Alabama Patients.

DIAGNOSTICS LAB

- Labs drawn inside our office are processed and billed to your insurance through a third party. If your insurance requires your labs to be processed by a specific company, please notify our staff.
- If you have any questions or concerns regarding a bill for labs you will need to contact the lab directly.

HIPAA PRIVACY NOTICE

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.

OUR COMMITMENT TO YOUR PRIVACY

It is our duty to maintain the privacy and confidentiality of your protected health information (PHI). We will create a records request regarding your health and the treatment and service we provide to you. We are required by law to maintain the privacy of your PHI, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the facility.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always

request a written copy of our most current privacy notice from our Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of treatment, payment, and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means providing services as ordered by your physician. Treatment also includes coordination and consultations with other health care providers relating to your care and referrals for health care from one health care provider to another. We may also disclose PHI to outside entities performing other services related to your treatment such as hospitals, diagnostic laboratories, home health or hospice agencies, etc.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, prior approval, determinations of eligibility and coverage and other utilization review activities. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release, when necessary, under applicable law.

Health care operations mean the support functions of the facility, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management, and administrative activities. We may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.
- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- To disclose to your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

We will use or disclose PHI about you when required to do so by applicable law.

In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer, or the facility as required by applicable law.

Note: Incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:
  - to prevent or control disease, injury, or disability.
  - to report births and deaths.
  - to report child abuse or neglect.
  - to persons subject to the authority of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products.
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
  - to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and

civil rights).

Lawsuits and Disputes. If you participate in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime under certain limited circumstances.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct on our premises; or
- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to perform their duties.

National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

You have the right to request restrictions on our use and disclosures of PHI for treatment, payment, and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to our office.

You have the right to request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.

You have the right to inspect and copy the PHI contained in our facility records, except:

- for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record).
- for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- for PHI involving laboratory tests when your access is restricted by law.
- if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you.
- If we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research.
- for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
- for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be likely to reveal the source of the information.

In order to inspect or obtain a copy of your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request. We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You have the right to request an amendment to your PHI, but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment.
- is not part of your medical or billing records or other records used to make decisions about you.
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to the Medical Records Custodian at our facility, along with a description of the reason for your request.

You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above.
(ii) incidental to a use or disclosure otherwise permitted or required by applicable law.
(iii) pursuant to your written authorization.

- to persons involved in your care or for other notification purposes as provided by law.
- for national security or intelligence purposes as provided by law.
- to correctional institutions or law enforcement officials as provided by law.
- as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our facility. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accounts, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive a notification if there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

You may 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 our customer service team. 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 at 1925 E Glenn Ave. Suite 203 Auburn, AL 36830. You can expect a written response within 14 working days of receipt. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington DC, 20201, or by calling Medicare at 1-800-MEDICARE.

EMERGENCY PLANNING

Infusion Care of East Alabama have provided this pamphlet to help you plan your actions in case there is a natural disaster where you live. Many areas of the United States are prone to natural disasters like hurricanes, tornadoes, floods, and earthquakes.

Every patient receiving care or services in the home should think about what they would do in the event of an emergency. Our goal is to help you plan so that we can try to provide you with the best, most consistent service we can during an emergency.

KNOW WHAT TO EXPECT

- If you have recently moved to this area, take the time to find out what types of natural emergencies have occurred in the past, and what types might be expected.
- Find out what, if any, time of year these emergencies are more prevalent.
- Find out when you should evacuate, and when you should not.
- Your local Red Cross, local law enforcement agencies, local news and radio stations usually provide excellent information and tips for planning.

KNOW WHERE TO GO

- One of the most important pieces of information you should know is the location of the closest emergency shelter.
- These shelters are opened to the public during voluntary and mandatory evaluation times. They are usually the safest place for you to go, other than a friend or relative's home in an unaffected area.

KNOW WHAT TO TAKE WITH YOU

- If you are going to a shelter, there will be restrictions on what items you can bring with you. Not all shelters have adequate storage facilities for medications that need refrigeration.
- We recommend that you call ahead and find out which shelter in your area will let you bring your medications and medical supplies, in addition, let them know if you will be using medical equipment that requires an electrical outlet.
- During our planning for a natural emergency, we will contact you and deliver, if possible, at least one week's worth of medication and supplies. Bring all your medications and supplies with you to the shelter.

REACHING US IF THERE ARE NO PHONES

- How do you reach us during a natural emergency if the phone lines do not work? How would you contact us? If there is warning of the emergency, such as a hurricane watch, we will make every attempt to contact you and provide you with the number of our cellular phone. (Cellular phones frequently work even when the regular land phone lines do not.)
- If you have no way to call our cellular phone, you can try to reach us by having someone you know call us from his or her cellular phone. (Many times, cellular phone companies set up communication centers during natural disasters. If one is set up in your area, you can ask them to contact us.)
- If the emergency was unforeseen, we will try to locate you by visiting your home, or by contacting your home nursing agency. If travel is restricted due to damage from the emergency, we will try to contact you through local law enforcement agencies.

AN OUNCE OF PREVENTION…

- We would much rather prepare you for an emergency ahead of time than wait until it has happened and then send you the supplies

you need.

- To do this, we need you to give us as much information as possible before the emergency. We may ask you for the name and phone number of a close family member, or a close friend or neighbor. We may ask you where you will go if an emergency occurs. Will you go to a shelter, or a relative's home? If your doctor has instructed you to go to a hospital, which one is it?
- Having the address of your evacuation site, if it is in another city, may allow us to service your therapy needs through another facility.

HELPFUL TIPS

- Get a cooler and ice or freezer gel-packs to transport your medication.
- Get all your medication information and teaching modules together and take them with you if you evacuate.
- Pack one week's worth of supplies in a plastic-lined box or waterproof tote bag or tote box. Make sure the seal is watertight.
- Make sure to put antibacterial soap and paper towels into your supply kit.
- If possible, get waterless hand disinfectant from a local store. It comes in very handy if you do not have running water.
- If you are going to a friend or relative's home during evacuation, leave their phone number and address with Infusion Care and your home nursing agency.
- When you return to your home, contact your home nursing agency and Infusion Care so we can visit and see what supplies you need.

FOR MORE INFORMATION

There is much more to know about planning for and surviving during a natural emergency or disaster. Review the information form FEMA http://www.fema.gov/areyouready/emergency_planning.shtm. The information includes:

- Get informed about hazards and emergencies that may affect you and your family. Develop an emergency plan.
- Collect and assemble disaster supplies kit, which should include:
- Three-day supply of non-perishable food.
- Three-day supply of water - one gallon of water per person, per day.
- Portable, battery-powered radio or television and extra batteries.
- Flashlight and extra batteries.
- First aid kit and manual.
- Sanitation and hygiene items (moist towelettes and toilet paper).
- Matches and waterproof container.
- Whistle.
- Extra clothing.
- Kitchen accessories and cooking utensils, including a can opener.
- Photocopies of credit and identification cards.
- Cash and coins.
- Special needs items, such as prescription medications, eyeglasses, contact lens solutions, and hearing aid batteries.
- Items for infants, such as formula, diapers, bottles, and pacifiers.
- Other items to meet your unique family needs.
- Learn where to seek shelter from all types of hazards.
- Identify the community warning systems and evacuation routes.
- Include in your plan required information from community and school plans.
- Learn what to do for specific hazards. · Practice and maintain your plan.

An Important Reminder!! During any emergency situation, if you are unable to contact our facility and you need your prescribed medication, equipment, or supplies, you must go to the nearest emergency room or other treatment facility for treatment.

SPECIAL NEEDS SHELTERS

Please note: The special needs shelter should be used as a place of last refuge. The evacuee may not receive the same level of care received from independent contractors in the home, and the conditions in a shelter might be stressful.

(1) If the patient has a caregiver, the caregiver must accompany the patient and must remain with the patient at the special needs shelter.

(2) The following is a list of what special needs patients need to bring with them to the special needs shelter during an evacuation:

- Bed sheets, blankets, pillow, folding lawn chair, air mattress.
- The patient's medication including the dose, frequency, route, time of day and any special considerations for administration, supplies and equipment list, including the phone, beeper and emergency numbers for the patient's physician, pharmacy and, if applicable, oxygen supplier; supplies and medical equipment for the patient's care; Do Not Resuscitate (DNR) form, if applicable.
- Name and phone number of the patient's nurse registry, if applicable
- Prescription and non-prescription medication needed for at least 5 to 7 days; oxygen for 5 to 7 days if needed.
- A copy of the patient's plan of care, if applicable
- Identification and current address
- Special diet items, non-perishable food for 5 to 7 days and 1 gallon of water per person per day
- Glasses, hearing aids and batteries, prosthetics, and any other assistive devices
- Personal hygiene items for 5 to 7 days
- Extra clothing for 5 to 7 days
- Flashlight and batteries
- Self-entertainment and recreation items, like books, magazines, quiet games.

(3) Shelter(s) need to know the following:

- If the patient has a caregiver, the caregiver(s) shall be allowed to shelter together in the special needs shelter. If the person with special needs is responsible for the care of individuals without special needs, those persons may also shelter together.
- The shelter caregiver will have floor space provided. The caregiver must provide his or her own bedding.

- Service dogs are allowed in the shelter. However, check with your local Emergency Management office to see if other pets are permitted.
- Bring personal snacks, drinks, and any special dietary foods for 72 hours. It is possible only sparse meals will be provided.
- Caregivers can be relatives, household members, guardians, friends, neighbors, and volunteers.

HOME SAFETY

At Infusion Care of East Alabama, we want to make sure that your home medical treatment is done conveniently and safely.
Many of our patients are limited in strength or unsteady on their feet. Some are wheelchair - or bed-bound. These pages are written to give our patients some easy and helpful tips on how to make the home safe for home care.

FIRE SAFETY AND PREVENTION

- Smoke detectors should be installed in your home. Make sure you check the batteries at least once a year.
- If appropriate, you may consider carbon monoxide detectors as well. Ask your local fire department if you should have one in your home.
- Have a fire extinguisher in your home, and have it tested regularly to make sure it is still charged and in working order.
- Have a plan for escape in the event of a fire. Discuss this plan with your family.
- If you use oxygen in your home, make sure you understand the hazards of smoking near oxygen. Review the precautions. If you are not sure, ask your oxygen provider what they are.
- If you are using electrical medical equipment, make sure to review the instruction sheets for that equipment. Read the section on electrical safety.

ELECTRICAL SAFETY

- Make sure that all medical equipment is plugged into a properly grounded electrical outlet.
- If you have to use a three-prong adapter, make sure it is properly installed by attaching the ground wire to the plug outlet screw.
- Use only decent quality outlet “extenders” or “power strips” with internal Circuit breakers. Do not use cheap extension cords.

SAFETY IN THE BATHROOM

- Because of the smooth surfaces, the bathroom can be a very dangerous place, especially for persons who are unsteady.
- Use non-slip rugs on the floor to prevent slipping.
- Install a grab-bar on the shower wall, and non-slip footing strips inside the tub or shower.
- Ask your medical equipment provider about a shower bench you can sit on in the shower.
- If you have difficulty sitting and getting up, ask about a raised toilet seat with arm supports to make it easier to get on and off the commode.
- If you have problems sensing hot and cold, you should consider lowering the temperature setting of your water heater, so you do not accidentally scald yourself without realizing it.

SAFETY IN THE BEDROOM

- It is important to arrange a safe, well-planned, and comfortable bedroom since a lot of your recuperation and home therapy may occur there.
- Ask your home medical equipment provider about a hospital bed. These beds are raised and lowered so you can sit up, recline, and adjust your knees. A variety of tables and supports are also available so you can eat, exercise, and read in bed.
- Bed rails may be a good idea, especially if you have a tendency to roll in bed at night.
- If you have difficulty walking, inquire about a bedside commode so you do not have to walk to the bathroom to use the toilet.
- Make sure you can easily reach the light switches, and other important things you might need throughout the day or night.
- Install night-lights to help you find your way in the dark at night.
- If you are using an IV pole for your IV or enteral therapy, make sure that all furniture, loose carpets, and electrical cords are out of the way, so you do not trip and fall while walking with the pole.

SAFETY IN THE KITCHEN

- Your kitchen should be organized so you can easily reach and use the common items, especially during your recuperation while you are still a bit weak:
- Have a friend or health care worker remove all common small appliances and utensils from cabinets and place them on your counters where you can easily use them.
- Have a chair brought into the kitchen to the counter work area if you have difficulty standing.
- Make sure you are careful lifting pots and pans. Not only might they be hot, but they can be heavy as well. Use padded mitts to firmly grasp pans and pots on both sides.
- Ask your kitchen or hardware store about utensils for manually impaired or arthritic persons, including:
    - Basic electric can openers
    - Bottle and jar openers
    - Large-handled utensils
    - When working at your stove, be careful that intravenous, tube feeding tubing, or oxygen tubing do not hang over the heat. They can be flammable.

GETTING AROUND SAFELY

- If you are now using assistant devices for ambulating (walking), here are some key points:
- Install permanent or temporary guardrails on stairs to give you additional support if you are using a cane or are unsteady.

- If you are using a walker, make sure that furniture and walkways are arranged to give you enough room.
- If you are using a walker or wheelchair, you may need a ramp for getting into or out of the house. Ramps can be purchased ready-made or may be constructed for you. Talk to your home medical equipment provider about available options.

If you have any questions about safety that are not in this booklet, please call us and we will be happy to give you recommendations for your individual needs.

INFECTION CONTROL

The patient/caregiver should observe all healthcare workers they meet and encourage and remind healthcare workers to wash their hands prior to providing care.

Items that touch only intact skin (e.g., blood pressure cuff, stethoscopes, thermometers, and other medical accessories) rarely, if ever, transmit disease. These items will be cleaned with alcohol after each use. Should any piece of item become contaminated with blood or other potentially infectious material, the item should be cleaned with a chemical germicide.

All excretions, secretions, blood, and drainage should be discarded in the toilet.

To minimize contamination during use, products must be handled in a manner that will protect them from contamination. These procedures include the following:

- Wash hands, making sure to use good hand washing technique.
- Unpack and handle products in a manner consistent with preservation of optimal cleanliness.
- Safely store all products.

MAKING DECISIONS ABOUT YOUR HEALTHCARE

Advance Directives are forms that say, in advance, what kind of treatment you want or do not want under serious medical conditions. Some conditions, if severe, may make you unable to tell the doctor how you want to be treated at that time. Your Advance Directives will help the doctor to provide the care you would wish to have.

Most hospitals and home health organizations are required to provide you with information on Advance Directives. Many are required to ask you if you already have Advance Directives prepared.

This pamphlet has been designed to give you information and may help you with important decisions. Laws regarding Advance Directives vary from state to state. We recommend that you consult with your family, close friends, your physician, and perhaps even a social worker or lawyer regarding your individual needs and what may benefit you the most.

WHAT KIND OF ADVANCE DIRECTIVES ARE THERE?

There are two basic types of Advance Directives available. One is called a Living Will. The other is called a Durable Power of Attorney.

A **Living Will** gives information on the kind of medical care you want (or do not want) if you become terminally ill and are unable to make your own decision.

It is called a "Living" Will because it takes effect while you are living.

- Many states have specific forms that must be used for a Living Will to be considered legally binding. These forms may be available from a social services office, law office, or a library.
- In some states, you are allowed to simply write a letter describing what treatments you want or do not want.
- In all cases, your Living Will must be signed, witnessed, and dated. Some states require verification.

A **Durable Power of Attorney** is a legal agreement that names another person (frequently a spouse, family member, or close friend) as an agent or proxy. This person would then be making medical decisions for you if you should become unable to make them for yourself. A Durable Power of Attorney can also include instructions regarding specific treatments that you want or do not want in the event of serious illness.

WHAT TYPE OF ADVANCE DIRECTIVE IT BEST FOR ME?

- This is not a simple question to answer. Each individual's situation and preferences are unique.
- For many persons, the answer depends on their specific situation, or personal desires for their health care.
- Sometimes the answer depends on the state in which you live. In some states, it is better to have one versus the other.
- Many times, you can have both, either as separate forms or as a single combined form.

WHAT DO I DO IF I WANT AN ADVANCED DIRECTIVE?

- First, consult with your physician's office or home care agency about where to get information specific to your state.
- Once you have discussed the options available, consult with any family members or friends who may be involved in your medical care. This is extremely important if you have chosen a friend or family member as your "agent" in the Durable Power of Attorney.
- Be sure to follow all requirements in your state for your signature, witness signature, notarization (if required), and filing.
- You should provide copies of your Advance Directive(s) to people you trust, such as close family members, friends, and/or caregivers. The original document should be filed in a secure location known to those to whom you give copies.
- Keep another copy in a secure location; if you have a lawyer, he or she will keep a copy as well.

HOW DOES MY HEALTH CARE TEAM KNOW I HAVE AN ADVANCED DIRECTIVE?

- You must tell them. Many organizations and hospitals are required to ask you if you have one. Even so, it is a good idea to tell your physicians and nurses that you have an Advance Directive, and where the document can be found.
- Many patients keep a small card in their wallet that states the type of Advance Directive they have, where a copy of the document(s) is located, and a contact person, such as your Durable Power of Attorney "agent," and how to contact them.

WHAT IF I CHANGE MY MIND?

- You can change your mind about any part of your Advance Directive, or even about having an Advance Directive, at any time.
- If you would like to cancel or make changes to the document(s), it is very important that you follow the same signature, dating, and witness procedure as the first time, and that you make sure all original versions are deleted or discarded, and that all health care providers, your caregiver(s), your family, and friends have a revised copy.

WHAT IF I DO NOT WANT AN ADVANCED DIRECTIVE?

- You are not required by law to have one.
- Many home care companies are required to provide you with this basic information, but what you choose to do with it is entirely up to you.

MORE INFORMATION

This pamphlet has been designed to provide you with basic information. It is not a substitute for consultation with an experienced lawyer or knowledgeable social worker. These persons, or your home care agency, can best answer more detailed questions, and help guide you towards the best Advance Directive for you.

Publication Date: 01/2025

Patient Consent Form

Today's Date_____

Patient Name: _____

Date of Birth: _____

_____**(Initials)** I have read and understand the **OFFICE POLICIES AND PATIENT RESPONSIBILITIES** and agree to all terms and conditions set forth herein.

_____**(Initials)** I have received the ***Notice of Privacy Practice*** from Infusion Care of East Alabama. I understand that I may request a copy of the Notice by asking the receptionist. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices* and to make changes regarding all protected health information under the control of this practice.

_____**(Initials) Evaluation and Treatment**. I consent to diagnostic procedures and medical care as deemed necessary in the judgment of my Physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. However, I understand that my Physician will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____**(Initials) Pharmacy Benefit Management (PBM).** Electronic Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Medication History Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, you agree that Infusion Care of East Alabama can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

_____**(Initials) Advanced Beneficiary Notice of Non-Covered Services (ABN/NNS).** As your physician and healthcare team, we/I want to provide you with the best possible care. There may be certain routine services/procedures performed during your visit(s), such as but not limited to; breathing test, patch testing, skin testing, food challenges, drug challenges, and/ or other test that we/I fee necessary for the maintenance of your good health that may not be covered by your insurance contract. These tests will only be ordered if deemed necessary to your treatment and care. Anything non-covered by your insurance contract you will be responsible for the total cost. Copayment, co-insurance, and deductibles may apply.

_____**(Initials) Government Compliance**. In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Infusion Care of East Alabama must inform you that there are other options pertaining to allergies, asthma, immunology, and pharmacy services. Specifically, it should be noted that you have presented to Infusion Care of East Alabama voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the clinician may determine that infusion and/or pharmacy services may be needed. Allergy, Asthma & Immunology Specialists and Medicus Specialty Pharmacy offers many of these services as a convenience to our patients. If any patient would like to have their allergy and pharmacy services provided at another location, we can provide you with a list of nearby locations which are available within a 25-mile radius. If I have no preference in providers, Allergy Asthma & Immunology Specialists and/or Medicus Specialty Pharmacy will be utilized. I am aware Infusion Care of East Alabama have an interest in those businesses. I authorize Infusion Care of East Alabama to release the necessary information concerning my case history, treatment, and examination for my visit to the above-named businesses.

_____**(Initials) Billing and Collections Policy.** We strive to provide exceptional care to all our patients, but we also must ensure financial sustainability. Patients are responsible for timely payment of co-payments, deductibles, and outstanding balances. If an account becomes past due and our efforts to collect payment are unsuccessful, then your account will be turned over to a Collection's Agency. Please note that accounts sent to the Collection Agency will incur **an additional 20% fee** on the outstanding balance to cover the collection costs. We encourage patients facing financial difficulties to contact our billing department for assistance with payment options as we are committed to finding reasonable payment solutions.

_____**(Initials) Medical Data Exchange.** Medical data may be exchanged through networks facilitated by the Interoperability Hub, such as Carequality and CommonWell. This enables seamless sharing of your health information among authorized healthcare providers for improved coordination and continuity of care.

[ ] Opt-In: I **do** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents

[ ] Opt-Out: I **do not** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents.

By signing below, I hereby agree and understand the Office Policies and Patient Responsibilities, Notice of Privacy Practice, Evaluation and Treatment, PBM, ABN/NNS, Government Compliance, Billing Collections Policy, and Medical Data Exchange:

Signed:_____ **Print:** _____ **Date:** _____/_____/_____

Patient

Signed:_____ **Print:** _____ **Date:** _____/_____/_____

Guardian

Guardian's Relationship to Patient: _____

Consent to Disclose
Medical Information Authorization

Today's Date_____

Patient Name: _____

Address: _____

_____

Date of Birth: _____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy rules.
3. I understand that I may revoke this authorization at any time by notifying our office in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the renovation, and Infusion Care of East Alabama will not be liable for any PHI released prior to me revoking this authorization.
4. I understand that by leaving spaces blank I am indicating that I do not want any medical information released to anyone else.
5. I understand that this authorization will expire: _____. ***(if no date this authorization will expire after 1 year)***

Disclose Information to the following:

(List any doctors or individuals you would like to have access to your information.)

Name:_____ Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

Guardian Information for Minors: ***(if guardians are not listed below, they will not have authorization to your medical records)***

Guardian Name:_____ Guardian Name: _____

Relationship to patient:_____ Relationship to patient:_____ _____

Phone number:_____ Phone number: _____

By signing below, I hereby authorize Infusion Care of East Alabama to release any or all my medical records to the following individuals, physicians, or companies:

Signed:_____ **Print:** _____ **Date:** ____/____/____

Patient

Signed:_____ **Print:** _____ **Date:** ____/____/____

Guardian

Guardian's Relationship to Patient:_____

Infusion Care of East Alabama
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 of East Alabama 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 of East Alabama financial hardship program.

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

Patients who have been set up with Copay Assistance for their specialty infusion or biologic medication must notify Infusion Care of East Alabama 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 of East Alabama.**

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 collection agency to collect and can have long-term effects on their credit.

I hereby agree that **Infusion Care of East Alabama** 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 of East Alabama.

I understand that I may 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 of 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 the 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: 06/2024

Patient Consent Form

Today's Date_____

Patient Name: _____

Date of Birth: _____

_____ **(Initials)** I have read and understand the **OFFICE POLICIES AND PATIENT RESPONSIBILITIES** and agree to all terms and conditions set forth herein.

_____ **(Initials)** I have received the ***Notice of Privacy Practice*** from Infusion Care of East Alabama. I understand that I may request a copy of the Notice by asking the receptionist. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices* and to make changes regarding all protected health information under the control of this practice.

_____ **(Initials) Evaluation and Treatment**. I consent to diagnostic procedures and medical care as deemed necessary in the judgment of my Physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. However, I understand that my Physician will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____ **(Initials) Pharmacy Benefit Management (PBM).** Electronic Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Medication History Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, you agree that Infusion Care of East Alabama can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

_____ **(Initials) Advanced Beneficiary Notice of Non-Covered Services (ABN/NNS).** As your physician and healthcare team, we/I want to provide you with the best possible care. There may be certain routine services/procedures performed during your visit(s), such as but not limited to; breathing test, patch testing, skin testing, food challenges, drug challenges, and/ or other test that we/I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. These tests will only be ordered if deemed necessary to your treatment and care. Anything non-covered by your insurance contract you will be responsible for the total cost. Copayment, co-insurance, and deductibles may apply.

_____ **(Initials) Government Compliance**. In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Infusion Care of East Alabama must inform you that there are other options pertaining to pharmacy services. Specifically, it should be noted that you have presented to Infusion Care of East Alabama voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the clinician may determine that pharmacy services may be needed. Medicus Specialty Pharmacy offers many of these services on-site as a convenience to our patients. If any patient would like to have their pharmacy services provided at another location, we can provide you with a list of nearby locations which are available within a 25-mile radius. If I have no preference in providers, Medicus Specialty Pharmacy will be utilized. I am aware Infusion Care of East Alabama has interest in that business. I authorize Infusion Care of East Alabama to release the necessary information concerning my case history, treatment, and examination for my visit to the above-named business.

_____ **(Initials) Billing and Collections Policy.** We strive to provide exceptional care to all our patients, but we also must ensure financial sustainability. Patients are responsible for timely payment of co-payments, deductibles, and outstanding balances. If an account becomes past due and our efforts to collect payment are unsuccessful, then your account will be turned over to a Collection's Agency. Please note that accounts sent to the Collection Agency will incur **an additional 20% fee** on the outstanding balance to cover the collection costs. We encourage patients facing financial difficulties to contact our billing department for assistance with payment options as we are committed to finding reasonable payment solutions.

_____ **(Initials) Medical Data Exchange.** Medical data may be exchanged through networks facilitated by the Interoperability Hub, such as Carequality and CommonWell. This enables seamless sharing of your health information among authorized healthcare providers for improved coordination and continuity of care.

[ ] Opt-In: I **do** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents

[ ] Opt-Out: I **do not** consent to the exchange of my medical data through networks facilitated by the Interoperability Hub for sending or receiving documents.

By signing below, I hereby agree and understand the Office Policies and Patient Responsibilities, Notice of Privacy Practice, Evaluation and Treatment, PBM, ABN/NNS, Government Compliance, Billing Collections Policy, and Medical Data Exchange:

Signed:_____ **Print:** _____ **Date:** _____/_____/_____

Patient

Signed:_____ **Print:** _____ **Date:** _____/_____/_____

Guardian

Guardian's Relationship to Patient:_____

Consent to Disclose
Medical Information Authorization

Today's Date_____

Patient Name: _____

Address: _____

_____

Date of Birth: _____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy rules.
3. I understand that I may revoke this authorization at any time by notifying our office in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the renovation, and Infusion Care of East Alabama will not be liable for any PHI released prior to me revoking this authorization.
4. I understand that by leaving spaces blank I am indicating that I do not want any medical information released to anyone else.
5. I understand that this authorization will expire: _____. ***(if no date this authorization will expire after 1 year)***

Disclose Information to the following:

(List any doctors or individuals you would like to have access to your information.)

Name:_____ Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

Guardian Information for Minors: ***(if guardians are not listed below, they will not have authorization to your medical records)***

Guardian Name:_____ Guardian Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____

By signing below, I hereby authorize Infusion Care of East Alabama to release any or all my medical records to the following individuals, physicians, or companies:

Signed:_____ **Print:** _____ **Date:** ____/_____/_____

Patient

Signed:_____ **Print:** _____ **Date:** ____/_____/_____

Guardian

Guardian's Relationship to Patient:_____