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 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 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:_____

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)	