CLIENT/PATIENT DOCUMENT ACKNOWLEDGEMENT

Name: _____

Address: _____

PATIENT DOCUMENT ACKNOWLEDGEMENT

I acknowledge receipt of the following standard patient documents:

- ☐ Basic Home Safety
- ☐ Emergency Preparedness
- ☐ Patient Satisfaction Survey
- ☐ Patient Bill of Right & Responsibilities
- ☐ Description of Services
- ☐ Billing & Collection Policies
- ☐ Information on Advanced Directives
- ☐ HIPAA Privacy Notice
- ☐ Verbal/written review of the Plan of Service/Care
- ☐ Welcome Packet
- ☐ Grievance/complaint procedure
- ☐ Infection Control
- ☐ Review of Copay
- ☐ Receipt Drug Monograph

Preferred method of contact for recurring deliveries:

☐**Cell Phone #:** _____ ☐ **Text Message #:** _____ ☐ **Home Phone #:** _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER

I request that payment of authorized Medicare, Medicaid, and other payer & benefits be made on my behalf to Total Health Care Specialty Pharmacy**,** for products & services that they have provided me. I further authorize a copy of this agreement to be used in place of the original & authorize any holder of Medical information including medical records to be released to Total Health Care Specialty Pharmacy as well as, any Federal, State or Accrediting Body or Agency as required by the Regulatory, Licensing or Accrediting Body, to determine these benefits or compliance with current healthcare standards . Total Health Care Specialty Pharma bills third-party as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowable, including charges related to deliver y before the verification of insurance benefits.

Primary Insurance #: _____ **Group #:** _____ **Effective Date:** _____

Secondary Insurance #: _____ **Group #:** _____ **Effective Date:** _____

INSTRUCTIONS TO CUSTOMER/RETURN DEMONSTRATION & ACKNOWLEDGMENT

I acknowledge receiving instructions & have demonstrated or verbalized my understanding in the proper use & care of the medication/equipment or supplies received this date. I have had my financial responsibilities explained to me and agree with the terms on the reverse side of this document. I have not rented or purchased the equipment listed through Medicare in the past & fully agree to this & all other documents received on this date.

HIPAA RELEASE

In accordance with the HIPAA Privacy Regulations, **Total Health Care Specialty Pharmacy (THCSPX)** may disclose to a member of your family, other relative, or a close friend, or any other person identified by you, the protected health information directly relevant to such persons involvement with your care or payment related to your health care. Please assist us by identifying below individuals who are involved in your care and/or in the payment of your care to whom a limited amount of information may be released. If there are no such individuals please indicate none.

PATIENT NAME (PLEASE PRINT)	PATIENT SIGNATURE	DATE

PATIENT'S AGENT OR REPRESENTATIVE (IF APPLICABLE)	RELATIONSHIP TO PATIENT (IF APPLICABLE)

Your signature evidences your understanding and agreement to these terms. Total Health Care Specialty Pharmacy is referred to as **THCSPX**. Patient personal information will be kept confidential by THCSPX. Patient must notify THCSPX of any medical status change such as a doctor's prescription, hospitalization, acquiring and infectious disease or change in residence. Patient agrees to notify THCSPX of Advance Directives being in place and any changes thereof.

_____ _____

Patient Name **Patient Signature**

_____

Date