5315 Avion Park Drive, Suite 120 ● Tampa, FL 33607
Phone (844) 650-5802 ● Fax (844) 277-0049

Service Agreement/Assignment of Benefits

PATIENT NAME: _____ Medical Record Number: _____

PURPOSE: This form is used to acknowledge receipt of our New Patient Packet and confirms your understanding and agreement with its contents.

CUSTOMER RIGHTS AND RESPONSIBILITIES: I acknowledge that I have been made aware of my rights and responsibilities asa customer and I understand them. Grievance/complaint procedures have been explained to me. Additionally, the purpose and hours of operation of the State home health hotline number have been provided and explained to me. I understand I have the right to choose my health care provider, and I choose PSG of Sarasota, LLC d.b.a. IV Solutions Rx (hereafter referred to as "the Company") for my infusion therapy, service, and/or equipment. I have also been advised I can purchase equipment that is routinely rented depending on my insurance coverage. I am aware that I am to return rental equipment in good condition, or I will be responsible for its replacement cost.

CONSENT FOR TREATMENT: I hereby give my permission for authorized personnel of the company to administer infusion therapy, provided equipment and/or services. I have been instructed by my physician about the prescribed treatment and understand the reasons why it is needed, its risks, advantages, possible complications, and alternatives. As with any therapy, I understand that there are unknown and known risks. I certify that no guarantee or promise—expressed or implied—have been made to me in conjunction with my treatment. I further understand that the provided therapy, service, or equipment will not be given in a medical facility and that I cannot be given immediate medical attention if complications arise. I have had the opportunity to discuss all these matters with my physician and voluntarily consent to receive home infusion therapy, services, and/or equipment. I understand that I may refuse treatment or terminate services at any time and the Company may terminate their services to me as explained in my orientation.

RELEASE OF INFORMATION: I acknowledge receipt of the Notice of Privacy Practices concerning Protected Health Information (PHI) and was given an opportunity to ask questions and voice concerns. I understand that the Company may use or disclose protected health information about me to carry out treatment, obtain payment or health care related operations. I hereby authorize the Company to release to or receive from hospitals, physicians or other agencies involved in my care all medical records and information pertinent to my care. I hereby give permission for the review of my medical record by the agencies accrediting and/or other regulatory bodies.

ASSIGNMENT OF BENEFITS /AUTHORIZATION FOR PAYMENT: I hereby assign and transfer to the Company all insurance benefits and payments to which Iam entitled from whatever source for any services, equipment or supplies which are furnished to me in conjunction with my home infusion therapy, services, and/or equipment, and I authorize the Company to seek such benefits and payments on my behalf. It is understood that the Company will bill insurers directly and that my assignment of benefits is ongoing and continuous unless and until canceled by me in writing to the insurer(s) providing coverage with a copy provided to the above-named Company. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to the release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payor be made on my behalf to the above-named Company.

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CMS MEDICARE DMEPOS SUPPLIER STANDARDS: I acknowledge receipt of the Medicare Supplier Standards and was given an opportunity to ask questions and voice concerns. I have been advised that I may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment (where Medicare will pay a monthly rental fee for a period not to exceed 13 months after which ownership of the equipment is transferred to the Medicare beneficiary. After ownership of equipment is transferred to a Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair). As a Medicare beneficiary (if applicable) I have been notified of warranty coverage. The Company will honor all warranties under applicable State law, and repair or replace free of charge Medicare covered equipment that is under warranty.

PAYMENT OF SERVICES RENDERED: I understand I am the responsible party for all medications and services rendered by the Company. I understand it is my responsibility to notify the Company of my insurance information, including prescription card information. I understand it is my responsibility to notify the Company of any changes in my insurance coverage. I understand it is my responsibility to pay for any medications and services rendered which are not covered or are rejected by my insurance carrier, for whatever stated reason. The Company will provide therapy, services and/or equipment agreed upon at order coordination to the patient. The estimated cost of each treatment will be communicated at time of order coordination. I understand the amount may vary depending on deductible and out-of-pocket expenses. I agree to make payment arrangements at the time of order coordination.

PRODUCT RETURNS: State Board of Pharmacy Regulations prohibits the return of dispensed prescription items. Personal hygiene, bathroom safety items, disposable supplies, nutritional products, oxygen contents and specially ordered products are not returnable. No credit will be issued for any unused or excess product. Credit will be issued for returned supplies only if shipped due to our error.

TRAVEL ASSISTANCE: I hereby authorize the Company to act as my agent in obtaining services from another company if I travel out of the service area while on service. I hereby release the Company from any liability in making these arrangements for me.

EDUCATIONAL MATERIAL: I acknowledge receipt of educational materials and all equipment, medication and supplies provided bythe Company have been explained to me. A home safety assessment was conducted during the admission process and applicable safety precautions materials were given to me.

AFTER HOURS / EMERGENCY INFORMATION: I understand for medical emergencies to call 911. I have been informed on how to contact the Company in the event of an emergency or after hours.

ADVANCE DIRECTIVES: I understand that the Federal Patient Self-Discrimination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak to myself.

PHARMACY CONSULTATION: I understand a pharmacist will be contacting me to prior to initiating therapy and periodically thereafter to discuss my drug therapy unless I explicitly decline such an offer for consultation. I further understand that a pharmacist familiar with my infusion therapy services is available to me 24 hours a day should I have any questions.

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INSTRUCTIONS: By completing and signing below, you affirm and agree to the above terms and conditions.

	NO	YES
I have made a Living Will (Declaration/Directive) If "No", please complete Advance Directive page. If "Yes", please provide a copy to the Company.		
I have made a Durable Power of Attorney for Health Care (Agent) If yes, provide the name and phone number of the person given power or attorney/agent below: Name: _____ Phone: _____		
I have an Emergency Contact who can reach me in case IV Solutions Rx cannot: If yes, provide the name and phone number of the person below: Name: _____ Phone: _____		

Patient Signature: _____Date: _____

Responsible Person or Legal Guardian Signature: _____Date: _____

Print Name of Personal Representative/Relationship to Customer: _____

Patient Unable to Sign Due to: _____