Patient Consent Agreement and Acknowledgement

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Patient Name (first and last): _____

Patient DOB: _____

Internal use only
RxHome #_____

Thank you for choosing Accredo. We look forward to serving your specialty pharmacy needs. As a pharmacy, we have an obligation to provide quality care, stay in compliance with all laws and regulations, protect your personal health information, and perform services as you direct. In order to meet those obligations, we are required to obtain your consent for some of the services that we may offer and provide disclosures to keep you informed of your rights as a patient when using our pharmacy.

By signing the acknowledgement below, you are indicating that we have provided you these disclosures, and that you are consenting to receive pharmacy services as a patient from Accredo. Please note that each patient and therapy is different, and that not all terms will apply or be relevant to your situation. If you have any questions or concerns about these terms, please contact Accredo.

1. CONSENT FOR PROFESSIONAL SERVICES:
You have a right to choose the pharmacy you use to receive your prescriptions and professional services, which may include consultation with pharmacists and nurses. By signing this Agreement & Acknowledgement, you are agreeing to receive pharmacy services from Accredo and our pharmacists and nurses. While providing services, you authorize Accredo to work with your other healthcare providers on your behalf.

2. RELEASE OF MEDICAL RECORDS AND INSURANCE INFORMATION:
I authorize the release of any medical or other information necessary to provide therapy, services, or products. I also request payment of government benefits either to myself or to the third party who accepts assignments according to the section below titled "Assignment of Benefits."

3. FINANCIAL RESPONSIBILITY:
I understand that if no insurance coverage exists for a product or service or the insurance provider fails to pay, I am financially responsible for the incurred charges. If a pump or pole is part of therapy received, all leased, loaned, or rented pumps and poles furnished by Accredo remain the property of Accredo. I am responsible for the replacement cost of lost, stolen, and/or damaged pumps.

4. ASSIGNMENT OF BENEFITS:
If the product or services provided are payable under a Medicare or other applicable government or commercial provided benefit, I authorize payment and medical benefits to Accredo for the therapy, services, and products supplied by Accredo.

5. PERSONAL REPRESENTATIVE:
I authorize Accredo to disclose and provide information regarding therapy, payment issues, and health-related issues to the person(s) listed below as patient's personal representative(s):

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Please return completed form to:
MedicalRecordsConsentForms@express-scripts.com

OR

Accredo Health Group, Inc.
3000 Ericsson Drive, Suite 100
Warrendale, PA 15086
ATTN: Accredo Medical Records Request
FAX: 866-495-6519

Please continue to next page>>

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IF YOU WILL RECEIVE NURSING SERVICES FROM ACCREDO, COMPLETE SECTION 6 BELOW. IF NOT, SKIP TO SECTION 7, PATIENT SIGNATURE.

6. ADVANCE DIRECTIVES:

Accredo is required by certain state laws and regulations to provide you with information about advance directives and your rights. Advance directives communicate what you want if you cannot speak for yourself, taking the burden off your family. When you have advance directives, your family and doctors know what treatments you do and do not want. If you receive nursing services from Accredo, you can share information about your advance directives with us so that we know your treatment preferences if you cannot speak for yourself. Accredo will not withhold services if you do not share your advance directives with Accredo.

ADVANCE DIRECTIVE ACKNOWLEDGEMENT:

If receiving nursing care from Accredo, I further acknowledge that I have been given an explanation of the rights under my state law to accept or refuse medical treatment and my right to formulate advance directives regarding such. I understand I am not required to have an advance directive in order to receive care from Accredo. I understand that I may request, and will be presented with, written material regarding formulating an advance directive if so desired. I agree to provide Accredo with a copy of the executed advance directives. I will inform Accredo of changes to any such advance directive.

I have executed the below documents, if applicable (please check all that apply):

- ☐ Living will
- ☐ Advance directive
- ☐ Medical durable power of attorney: _____
- ☐ Appointment of surrogate: _____
- ☐ I do not have an advance directive.
- ☐ I would like information regarding formulating an advance directive specific to the state of _____

7. PATIENT SIGNATURE:

Patient signature (or legal guardian or parent):_____

Date: _____ Patient relationship:_____

Print name of signatory(first and last name): _____

Only necessary for Advanced Directive:

Print name of witness(first and last name): _____

Witness signature:_____

Date: _____ Patient relationship: _____