Consent for treatment and consent for the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment; A means of communication among the many health professionals who contribute to my care; A source of information for applying my diagnosis and surgical information to my bill; A means by which a third-party payer can verify that services billed were actually provided, and; a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I am aware that intravenous medications may be provided on an outpatient basis. These medications and the procedures necessary to administer them require close monitoring and follow-up. The purpose of my therapy has been explained to me, including a discussion of all the procedures involved. My various treatment options have been explained to me.

I have been instructed as to the potential adverse effects of the medications I am to receive and understand that periodic examinations and blood tests will be done to determine my response and possible adverse effects.

I understand that this therapy may be given in a facility where immediate attention is not available. I understand that treatment at home may be of more risk than in-hospital or in-office treatment. I have been instructed in the steps to minimize risks and to identify and report problems. I understand that I may telephone the I.V. therapy nurse or physician at any time and will do so if I have any questions or problems.

I understand that Intravene is a part of Dr. Robert Brennan, Dr. Scott Wade, Dr. Joseph Saabiye, Dr. Kensley Nichols and Dr. Sarah West's practice. I understand that I am under no obligation to use the services of Intravene and that I may use another provider if I choose.

If I am to be treated in the Roanoke, Danville, or Charlottesville location, I authorize my prescription to be processed in the Lynchburg facility pharmacy and delivered to the alternate care site where I will receive my infusion or injection. I understand it will be stored in a secure location in appropriate storage conditions.

I understand that I have the right to have my questions answered during my participation and that I may withdraw from this program at any time.

I agree that equipment such as I.V. poles and pumps are and continue to be the property of Intravene. I agree to return all equipment to Intravene and I understand that I am financially responsible for loss or damage to any equipment.

I have received the Patient Bill of Rights and understand that I have the right to freely voice grievances without fear of reprisal or interruption of services.

I authorize the release of any medical information to my insurance carrier which is necessary to process my insurance claims. I also authorize my insurance benefits to be paid directly to Intravene, realizing I am responsible to pay for non-covered services. I understand and agree that I will be responsible for all Collection Agency and or Attorney fees should my delinquent account be turned over for collection.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

I authorize the release of my laboratory results or test, scheduling or changing appointments and reminders of upcoming appointments, to verify if I am ready to be picked up from my visit and/or to pick up prescriptions, to speak to the Finance Department regarding my account/billing and any other special requests to:

(1) _____ Relationship: _____ Telephone #:_____
(2) _____ Relationship: _____ Telephone #:_____
(3) _____ Relationship: _____Telephone #:_____

I authorize Intravene to send reminder notices of upcoming appointments to me or to leave messages on my telephone answering machine. Yes ___ No_____

I have Received, Read, and I understand advance directives and I do _____ do not_____ have a living will. I fully understand and accept/decline the terms of this consent.

_____ _____ _____

Signature DOB Date