FLOMED INFUSION

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PATIENT CONSENT FOR TREATMENT FORM

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, and tests provided by FloMed Infusion Services LLC and its associates, physicians, providers, nurses, and clinicians (collectively called "Clinicians"). I understand that in many instances the Clinicians are carrying out orders from my referring health care provider(s). Although I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that FloMed Infusion Services LLC and the Clinicians will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if any employee or any individual associated with FloMed Infusion Services LLC is exposed to my blood or body fluids, I will be tested for Hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to exposure.

HEPATITIS B VIRUS CONSENT

If I have not had the Hepatitis B Virus (HBV) vaccine, or should I refuse the vaccine, I understand that due to my exposure to potentially infectious material, that I may be at risk of catching HBV, which can be potentially life-threatening.

PREGNANCY AND BREASTFEEDING CONSENT (biological female patients)

☐ I am not pregnant, and do not suspect that I am. I am aware of the potential risks to an unborn fetus should I become pregnant while being treated. If I become pregnant during treatment, I will notify FloMed Infusion Services LLC Clinicians immediately.

☐ I am pregnant, but will continue treatment. I have discussed this with my healthcare provider, and I know the potential risks to the fetus.

☐ I am breastfeeding, but will continue treatment. I have discussed this with my healthcare provider, and I know the potential risks to the fetus.

CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD

I authorize FloMed Infusion Services LLC to photograph, videotape, or record me and agree that the images, video, or recordings may be used for medical reasons including training, education, and research. I hereby release FloMed Infusion Services LLC and its employees from any responsibility which might arise from the taking and authorized use of such photographs, videos, or recordings.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledgment that I have received or been offered a copy of FloMed Infusion Services LLC's HIPAA Notice of Privacy Practices, which provides information on how FloMed Infusion Services LLC may use or disclose my personal health information.

ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to FloMed Infusion Services LLC for services provided to me. I understand that benefits may be payable to me if I do not provide authorization.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all medications provided or services rendered to me which are not eligible for insurance payments. Non-covered products and services also may include products and services that FloMed Infusion Services LLC and the Clinicians determined to be medically necessary but later determined by insurance as unnecessary or denied by my insurance provider.

USE OF INFORMATION

Electronic Health Records: I understand that FloMed Infusion Services LLC may collaborate with other health care providers to coordinate, manage and provide health care to me. I voluntarily consent to FloMed Infusion Services LLC's sharing of my health information, electronically or otherwise for the purpose of treatment, payment and operations. **Request for Information from Others:** I consent to FloMed Infusion Services LLC's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal or electronic.

PERSONAL PROPERTY

I understand that FloMed Infusion Services LLC does not accept responsibility for any lost, stolen or damaged personal property while I am at FloMed Infusion Services LLC.

PATIENT SIGNATURE AND DATE

Patient Signature: _____ Today's Date: _____