TOTAL INFUSION CARE
RESPONSIBILITY FOR LIFE

# TOTAL INFUSION CARE, TIC, Inc.
# RESPONSIBILITY FOR LIFE

## Assignment of Direct Payment to TIC and Assignment of Insurance Rights and Benefits To TIC

I hereby authorize my insurance company, self-funded plan, Medicare, Medicaid, or third-party payers to make direct payment to Total Infusion Care, ("TIC") for any and all services, treatments, medication(s) and supplies provided to me by TIC. I further, authorize my insurance company, self-funded plan, Medicare, Medicaid, or third-party payers to furnish to any agent, designee or representative of TIC any and all information pertaining to my medical coverage, benefits and status of claims submitted by TIC for services, treatment and medications rendered or supplied to me.

I also assign to TIC any and all of my rights to pursue any remedy that might accrue to me as a result of the failure of my insurer(s) or third party payer(s) to reimburse for services, treatments, medication(s) and supplies rendered to me under this Agreement, including without limitation all my rights under the Employment Retirement Income Security Act of 1974 ("ERISA"), the right to investigate, appeal and seek reconsideration of denied claims, the right to prosecute and file lawsuits, to prosecute administrative hearings or to take other necessary and appropriate actions on my behalf in order to recover payment, benefits or insurance proceeds.

Name: _____ Date: _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Total Infusion Care
Telephone: (702) 778-8880 Fax: (702) 778-8882
3041 W. Horizon Ridge Parkway, Suite 100
Henderson, NV 89052


# Total Infusion Care

3041 W. Horizon Ridge Parkway Suite 100, Henderson, NV 89051 Phone: (702) 778-8880 Fax: (702) 778-8882

## PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENTS NAME: _____

The normal business hours of Total Infusion Care. ("TIC") are Monday thru Friday from 9 a.m. to 5 p.m. A pharmacist is also on-call for after-hours emergency services related to your treatment. PLEASE CALL: 911 for life threatening situation(s).

Your home health agency for nursing related issue (name/phone):_____

Your attending physician for the prescribed therapy (name/phone):_____

**As a client, you have the right to:**

- Consult with your home care pharmacist about your medications, pump, catheter care and infusion therapy.
- Receive this notice before the initiation of care.
- Be treated with dignity, consideration and respect by trained professional staff.
- Voice grievances about your care or lack of respect for property without being subject to discrimination or reprisal. Please report any grievances to TIC's Pharmacist by calling 702-778-8880. The Pharmacist will attempt to resolve the problem with verbal or written response within 15 days from your complaint. If you are not satisfied with the resolution, a complaint may be made to the Nevada Division of Public and Behavioral Health, 3811 West Charleston Blvd #104 Las Vegas, NV 89102 (702) 486-5403
- Know in advance if you will be responsible for any costs other than your own co-payment and yearly deductible that are pre-determined by your medical insurance policy and Medicare/ Medicaid regulations.
- Be informed by a physician of your medical condition and be given an opportunity to participate in designing a care plan for your needs and updating it as your condition changes.
- Expect confidentiality of all personal information related to your care, within regulations.
- Refuse treatment and to be told the consequences of your action.
- Be informed within a reasonable time of anticipated termination of service.
- Have your family informed about your treatment so that you can help yourself and the family can help you. Choose freely among available providers and to change providers after services have begun within the limits of health insurance
- Contact ACHC at (855) 937-2242 and Fax: (919) 785-3011 of any problems with your medical care provided by TIC.

**As a client, you have the responsibility to:**

- Remain under a doctor's care while receiving pharmacy services.
- Provide the pharmacy with a complete and accurate history and any medication you are taking. Provide the pharmacy all requested insurance and financial records.
- Sign the Agreement and Consent Form and Patients' Rights and Responsibilities Form.
- Participate in your plan of care, coordinate and cooperate with your doctor, home health nurse and ether caregivers.
- Read the drug information and catheter care information given to you.
- Treat pharmacy personnel with respect and consideration.
- Advise the pharmacy of any problems or dissatisfaction with the care, without being subject to discrimination or reprisal. Notify the pharmacy when unable to accept a delivery or there is change in address or therapy or place to leave delivery. Notify the pharmacy to pick up unused equipment and sharp container
- Notify pharmacy of hospitalizations.
- Provide a safe home environment in which your care can be given.
- Comply with your therapy as ordered
- Be financially responsible for TIC equipment if it is not returned, or if damaged from negligence or misuse. An estimate value of your equipment is $ 6000.00, if a pump and supplies are provided for treatment
- Notify the pharmacy when you become independent and no longer need a home health agency.

PATIENT/GUARDIAN SIGNATURE: _____ DATE_____

TOTAL INFUSION CARE
RESPONSIBILITY FOR LIFE

PATIENT NAME: _____

# Total Infusion Care, TIC, Inc.

3041 W. Horizon Ridge Parkway Suite 100, Henderson, NV 89051 Phone: (702) 778-8880 Fax: (702) 778-8882

## AGREEMENT AND CONSENT

### TERMS OF AGREEMENT AND MEDICAL CONSENT

I understand that by signing this Agreement that I am authorizing the provision of products and medical services to me by Total Infusion Care, TIC, Inc. ("TIC"). I also understand that I will also remain under the medical care of my Physician during the course of my treatment. My Physician has explained the nature, risk and possible complications and consequences of home infusion to me, and I hereby consent to the therapy.

I understand that if I request additional home health services that are not provided by TIC, TIC may suggest the name of another provider who is not owned or operated by TIC, whom I can choose to use or not to use for these other services. I will not hold TIC responsible or liable for the services furnished by another provider or for the consequences of any services furnished by another provider, nor will I hold TIC responsible or liable for providing the names of other home care providers.

### MEDICAL INFORMATION AUTHORIZATION

Pursuant to California's Confidentiality of Medical Information Act ("CMIA") (Civil Code Section 56, *et seq*.), I authorize my hospital, physician, nursing agency or other health care provider to release to TIC all records relevant to my medical history and the medical services to be rendered to me by TIC. I also authorize TIC and any accreditation company associated with TIC to examine my medical records for the purpose of quality assurance compliance.

### ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment to TIC of any insurance benefits for products and/or medical services provided to me by TIC. I authorize my insurance company, health benefits plan, Medicaid and Medicare to furnish to any agent, designee or representative of TIC any and all information pertaining to my medical coverage benefits and status of any claims submitted by TIC for medical services and products rendered or provided to me. I assign to TIC all my rights to pursue any remedy that might accrue to me because of any failure of my insurer and/or health benefits plan failure to reimburse TIC of medical services and products rendered and provided to me, including, without limitations, **ALL** my rights under the Employment Retirement Income Security Act of 1974 ("ERISA"), including my rights to request plan documents from my health benefits plan and/or insurer.

### ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that it is my responsibility to inform TIC any time there is a change in my medical benefits coverage, whether it is a change in coverage or a change in health plans. If I fail to inform TIC of any such changes, TIC may exercise its rights to bill me for the medical services and products provided.

Medical Benefits Plan/Insurer and Policy No. _____

Pre-Authorization/Verification No. _____

Share of Costs under Health Benefits Plan (i.e., 50/50, 60/40): _____

Deductible: _____ Co Pay Amount: __N/A___ Annual Maximum Out of Pocket _____

If Medicare, Medicare Pays 80% of Medicare Allowable with remaining 20% paid by: _____

Per-telephone Conversation/Agreement with: _____

I understand that I am financial responsible for all medical services and products provided to me by TIC. If for any reason TIC is not reimbursed by my insurer or health benefit plan, I understand that I will be financial liable for all such all medical services and products provided to me by TIC.

Any claim or controversy arising out of or in relation to this agreement will be resolved in any court having jurisdiction over this matter. If any action or proceeding is brought in relation to the medical services and products provided by TIC under this Agreement or to enforce or interpret the provision of this Agreement, the prevailing party shall be entitled to recover its reasonable attorneys' fees and costs from the other party.

### RETURN GOODS POLICY

I understand that none of the drugs and most of the ancillary supplies dispensed to me may not be returned to TIC for credit. To the extent that I have any ancillary supplies and equipment owned by TIC, I agree to return such ancillary supplies and equipment to TIC in good condition at the end of my treatment. I understand that if I fail to return the TIC owned equipment or return damaged TIC owned equipment, I will be held financially liable for the equipment.

### AUTHORIZATION TO ACCEPT DELIVERY

If the patient or patient's spouse or legal guardian is unable to sign for the delivery, authorized representatives who can accept delivery are as follows:

1. Name (Print): _____ Relationship: _____ Date: _____
2. Signature of Patient/ Guardian: _____ Date: _____