Fax 1-732-960-3449 · Phone 732-444-8808
301 Lakehurst Rd, Suite 301, Toms River, NJ

Patient Rights & Consents

InfuseCare Medical Management, d/b/a Infuse Care

PATIENT RIGHTS

Every patient's rights include, but are not limited to, the following:

1. To be fully informed of care and services provided by Infuse Care and your financial responsibility.
2. To be treated with respect and dignity, free from discrimination.
3. To be assured confidentiality in treatment and records.
4. To approve and/or refuse release of information to any outside vendor, unless being transferred to another facility or company or as required by law or third-party payment contract.
5. To have access to the physician coordinating your care.
6. The right to view information regarding your diagnosis and treatment.
7. To be educated on the Infuse Care procedure for receiving, reviewing, and resolving your complaints.
8. To obtain a thorough and clear explanation of the total invoice for services rendered and products supplied to you.
9. To receive care in a timely and appropriate manner to suit your needs.
10. To be treated with respect, consideration and recognition of patient dignity and individuality.
11. To obtain care free of abuse, i.e., mental, physical, or emotional.
12. To have knowledgeable and competent healthcare professionals provide your care.
13. To decline treatment and supplies, as permitted by law, and be knowledgeable of the health risk of such refusal.
14. To partake in the plan of care of your treatment.
15. To be able to identify all personnel through proper identification.
16. To voice grievances or complaints.
17. To confidentiality and maintenance of privacy for all PHI.
18. To be advised of Infuse Care's policy of disclosure of records.
19. Receive information about the scope of services the organization will provide and any specific limitations on those services, prior to the initiation of care when possible.
20. Be informed of the right under state law to formulate an Advance Directive and to have the organization comply with that directive in accordance with applicable law. The organization will document whether the patient has an Advance Directive.
21. Voice grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property, have those complaints investigated, and receive a timely response without fear of discrimination or reprisal.
22. Choose a healthcare provider, including an attending physician when applicable, and to be informed of any limitations to that choice.
23. Receive appropriate care without discrimination in accordance with physician's orders, if applicable.
24. Be informed of any financial benefits to the organization when the patient is referred to the organization.

PATIENT RESPONSIBILITIES

Every patient has responsibilities that include, but are not limited to, the following. Infuse Care reserves the right to discharge any patient who fails to adhere to these standards of conduct.

1. To provide, to the best of your knowledge, accurate and complete information about present medications and health conditions.
2. To inform Infuse Care personnel of any changes in condition to the appropriate healthcare staff.
3. To follow the treatment plan exactly as ordered by your physician.

4. To make sure all appointments are kept and, if for any reason your appointment cannot be kept, contact Infuse Care to cancel/reschedule.
5. To at all times respect all Infuse Care personnel regardless of race, sex, orientation, creed, and/or age.
6. To respect all Infuse Care equipment and property.
7. To fulfill all monetary obligations to Infuse Care in a timely manner.
8. Minors and visitors must abide by patient responsibilities and should remain within designated patient rooms at all times unless authorized by Infuse Care staff, to help maintain privacy and HIPAA compliance.

COMPLAINTS AND GRIEVANCES

You have the right to file a complaint with Infuse Care personnel or directly with the Office for Civil Rights if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. You may obtain the address of the U.S. Department of Health and Human Services Office for Civil Rights regional office from our Compliance Officer.

This notice was published and becomes effective on _____

☐ I acknowledge that I have received the Infuse Care Patient Welcome Packet, including information regarding emergency preparedness; how to contact Infuse Care; how to submit a grievance or complaint; the process for investigating and resolving grievances/complaints; and how to contact our accrediting organization regarding concerns or complaints.

Patient name * _____ Date * _____

Signature _____

CONSENT FOR TREATMENT

I consent to treatment and care involving diagnostic tests, procedures, and therapies ordered by my healthcare provider and performed by the clinicians at Infuse Care, including their assistants or designees. I authorize Infuse Care to access my laboratory results through electronic lab portals for the purpose of reviewing and utilizing required lab work related to my care. I have had the opportunity to discuss the possible risks, benefits, side effects and contraindications of the prescribed treatment with my ordering provider, and have been given sufficient information to make an informed decision. No guarantee has been given to me as to the results that may be obtained from my care, and I understand that I have the right to refuse the recommended therapy at any time.

FINANCIAL RESPONSIBILITY

I acknowledge and agree to the following financial responsibilities related to the healthcare services provided by Infuse Care:

- **Payment responsibility:** I understand that I am financially responsible for all charges incurred for the services provided by the healthcare office. This includes, but is not limited to, copayments, deductibles, and any services not covered by my insurance plan.
- **Insurance coverage:** I acknowledge that it is my responsibility to provide accurate and up-to-date insurance information to the healthcare office. I understand that any discrepancies in the provided information may result in additional charges that I am liable for.
- **Financial liability:** In the event that my insurance company does not cover the entire cost of services provided, I accept full financial responsibility for all outstanding balances.
- **Payment agreement:** I agree to make payment for services rendered promptly. I understand that payment is due at the time of service unless prior arrangements have been made with the healthcare office. The practice may also deny service for failure to pay any outstanding balance at the time of service.

- **Credit card on file:** I authorize Infuse Care's third-party payment processor to securely store credit card information and charge my card on file for my patient responsibility (copay, deductible, coinsurance, or balance) for each visit. I understand that this information will only be used if payment is needed and will be processed only after I have been informed of the charges.
- **Payment plan:** I can request the option to set up a payment plan to settle any outstanding balances. If a payment plan is established, I authorize the healthcare office to charge my credit card automatically on a recurring basis, as agreed upon, until the balance is paid in full. I acknowledge that I can modify or cancel the payment plan by providing written notice to the healthcare office.
- **Collection costs:** I understand that any unpaid account may be assigned to an agency or attorney for collection and agree to the assignment of all third-party payor benefits to Infuse Care, its clinicians, providers or designees. I understand that if my account becomes past due, I will be responsible for any collection fees, attorney fees, or court costs incurred by the healthcare office in their efforts to collect the outstanding balance.
- **Financial queries:** I acknowledge that I have the right to inquire about any charges or fees associated with the services provided. I understand that I can request an explanation of charges from the healthcare office.

NOTICE OF PRIVACY PRACTICES

I understand that Infuse Care must keep my health information confidential, but may legally use my health information for purposes of treating me, getting paid for services provided to me, coordinating my care, or as otherwise necessary for internal operations. I acknowledge that I have read and/or received and agree to the terms of the Notice of Privacy Practices and Patient Rights and Responsibilities from Infuse Care.

COPAY ASSISTANCE AND ASSIGNMENT OF BENEFITS

If I qualify for copay assistance, I give permission for Infuse Care staff to enroll me in any eligible copay assistance program as applicable to my treatment and coverage.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, the undersigned, hereby authorize Infuse Care, its employees, agents, and affiliates to use or disclose my Protected Health Information (PHI) until completion of services rendered. This authorization is provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The information may be shared with health insurance companies and drug manufacturers, and the information to be used or disclosed may include, but is not limited to, the following types of information: 1) medical records; 2) laboratory results; 3) treatment plans and notes; 4) billing and payment information; 5) appointment history; 6) other patient documents. Infuse Care may receive compensation for these activities.

I agree to communicating with Infuse Care by secure email, phone calls, and standard SMS text messaging regarding my medical care, protected health information (PHI), patient experience, and customer feedback, which may be shared with my ordering provider. I understand that my feedback may be shared for promotional purposes but details related to my identity and medical information will never be released.

I authorize the following individuals to discuss my care, such as dates/times of upcoming appointments or status of referrals. *Authorized individuals (leave empty if none):*

#	NAME OF PERSON	RELATIONSHIP	CONTACT INFORMATION	INFORMATION AUTHORIZED TO BE RELEASED
1				
2				
3				

I certify that I have had the opportunity to read/review this form and all referenced attachments (or had them read to me). I agree that a copy of this consent, release and assignment of benefits may be used in place of the original. I understand that I am entitled to a copy of same if I make such a request and that this consent, release, and assignment are valid until rescinded in writing or replaced by one of a later date.

Patient name * _____ Date of birth * _____

Patient signature * _____ Date * _____

The undersigned certifies that the patient is (unable to consent) / (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Guardian signature (if applicable) _____ Date _____