COMPLETE INFUSION CARE

RESPONSIBILITY FOR LIFE

COMPLETE INFUSION CARE, CIC, Inc.
RESPONSIBILITY FOR LIFE

Assignment of Direct Payment To CIC and Assignment of Insurance Rights and Benefits To CIC

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

I also assign to CIC 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: _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Complete Infusion Care, CIC, Inc.
Telephone: 310-836-6666 Fax: 310-836-6675
2310 S. SEPULVEDA BLVD, LOS ANGELES, CA 90064

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2310 South Sepulveda Blvd, Los Angeles, Ca 90064
Tel: (310) 836-6666 Fax: (310) 836-6675

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENTS NAME: _____

The business hours of Complete Infusion Care. CIC Inc. ("CIC") are Monday thru Friday from 10 a.m. to 5 p.m. A pharmacy staff is also on-call for after-hours services for your treatment. 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 any grievances about your care without being subject to discrimination or reprisal. You can report any grievances to CIC's Pharmacist at 310-836-6666. The Pharmacist will attempt to resolve any issue with a 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 California Department of Health Services, 600 South Commonwealth Avenue, Suite 903 Los Angeles, CA 90005, (800) 228-1019
- 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/ Medi-Cal 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.
- Having 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 if you have problems with your care provided by CIC.

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 Patient's 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 pharmacy of any problems with your care without being subject to discrimination or reprisal.
- Notify the pharmacy if unable to accept a delivery or change of address or therapy or place to leave delivery.
- Notify the pharmacy to pick up unused equipment and sharp container
- Notify pharmacy immediately of hospitalizations.
- Provide a safe home environment in which your care can be given.
- Comply with your therapy as ordered
- Be financially responsible for CIC 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 SIGNATURE_____DATE_____

LEGAL GUARDIAN: _____ DATE: _____

PATIENT NAME: _____

Complete Infusion Care, CIC, Inc. ("CIC")

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AGREEMENT AND CONSENT

TERMS OF AGREEMENT AND MEDICAL CONSENT

I understand that by signing this Agreement I am authorizing that products and medical services will be provided to me by CIC. I understand that I will remain under the medical care of my Physician during my treatment. My Physician has explained the nature, risk and consequences of home infusion therapy to me, and I hereby consent to the therapy.

I understand that if I request additional home health services not provided by CIC, that CIC may suggest another provider not owned or operated by CIC, whom I can choose to use or not for those other services. I will not hold CIC responsible for services furnished by another provider or for the consequences of any services furnished by another provider.

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 all records related to my medical history and the medical services to be rendered to CIC. I also authorize CIC and any accreditation company associated with CIC to examine my medical records for quality assurance compliance purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment to CIC of any insurance benefits for products and/or medical services provided to me by CIC. I authorize my insurance company, health benefits plan, CalOptima/MediCal and Medicare to furnish to any agent, designee or representative of CIC any and all information pertaining to my medical coverage benefits and status of any claims submitted by CIC for medical services and products provided to me. I assign to CIC all my rights to pursue any remedy that might accrue to me based on any failure of my insurer and/or health benefits plan to reimburse CIC for medical services and products provided to me, including, without limitations, ALL my rights under the Employment Retirement Income Security Act of 1974 ("ERISA"), including 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 CIC if there is any change in my medical benefits coverage, whether it is a change in coverage or a change in health plans. If I fail to inform CIC of any such changes, CIC 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: _____ Annual Maximum Out of Pocket _____

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

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

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 CIC 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 the drugs and supplies dispensed to me may not be returned to CIC for credit. To the extent that I have any supplies and equipment owned by CIC, I agree to return such supplies and equipment in good condition at the end of my treatment. I understand that if I fail to return the CIC owned equipment or return damaged CIC 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: _____ Relationship: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

PATIENT NAME: _____

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NOTICE OF PATIENT'S PRIVACY RIGHTS

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practice (NPP) describes how we use and disclose your Protected Health Information (PHI) to carry out healthcare operations, treatment, obtain payment and other pre-determined purposes permitted or required by law. This NPP explains the rights of an individual with respect to their PHI. This NPP describes how we may use PHI and your rights related to that information. Please read carefully:

OUR RESPONSIBILITIES

We are required by law to protect and maintain the privacy of your health information, to provide this NPP about our legal duties and privacy practices regarding PHI and to abide by the terms of this NPP.

YOUR RIGHTS

You have the right to inspect and get a copy your PHI. If you feel that the PHI is incorrect or incomplete you may request it be corrected. Reasoning for the request must be included. We may deny your request if it is not in writing or if it lacks a reason to support it. You have the right to request a list of instances where we have disclosed your PHI for reasons other than treatment, payment or other related administrative purposes. You have the right to request a limit be placed on the PHI we disclose to someone who is involved in your care or payment for your care. You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we only contact you at work or by mail. You have the right to a paper copy of this NPP.

USE & DISCLOSURES OF YOUR PHI

You have been asked to sign an acknowledgment that you received a copy of this NPP, describing how we may use and disclose your PHI. The following categories describe different ways that we use and disclose medical information:

- We use your PHI to provide you with medical treatment. We disclose medical information about you to doctors, nurses, technicians, and other healthcare personnel who may help to take care of you. For example, pharmacy obtained information may be used to dispense prescribed medication.
- There are some services provided to our organization through contacts with a Business Associate (BA), examples include nursing agencies and labs. To ensure that a BA can perform the duties for which we are using with them and to bill for services rendered, we may disclose PHI to a BA. In such instances, a BA is required to appropriately safeguard PHI to protect the patient.
- Communication. We may disclose PHI about your personal care or payment related to care to those identified by you, like family, relatives and friends.
- FDA. To enable the FDA to recall, repair, or replace products, we may disclose to the FDA, or those persons under its jurisdiction, PHI associated with adverse outcomes with respect to food, drugs, products and product defects, supplements.
- Worker's Compensation. An individual's PHI may be disclosed if necessary to act in accordance with any laws regarding worker's compensation or similar law established programs.
- Public Health. PHI regarding the prevention and control of disease, injury and disability may be disclosed to public health or legal authorities as required by law.
- Law enforcement. As required by law for law enforcement purposes, a valid subpoena, or another legal process, we may disclose an individual's PHI.
- Health Oversight Activities. For any lawful authorized activities, we may disclose PHI to an oversight agency. Such activities include inspections, investigations and audits deemed necessary for the government and the licensure to monitor government programs, the healthcare system and compliance with civil rights laws.
- Judicial and Administrative Proceedings. PHI may be disclosed by an administrative court order if an individual is involved in a lawsuit or dispute. Should someone else involved in the dispute request PHI via a subpoena, lawful process, PHI may be disclosed only if an effort has been made to notify the individual or obtain an order requested to protect the PHI.
- Research. Upon approval from an institutional review board that has established protocols ensuring the protection of PHI from a formal review of the research proposal, researchers may request an individual's PHI.

PATIENT NAME: _____

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- Coroners, Medical Examiners and Funeral Directors. We may release PHI to a medical examiner or coroner for the purposes of, but not limited to, determining the identity of the deceased person or cause of death. PHI may also be disclosed to funeral directors in fulfilling their duties in accordance with applicable laws.
- Organ and tissue Procurement Organization. For the purposes of organ donation and transplanting, PHI may be disclosed to an organization involved in procurement, banking or transplantation of organs.
- Fundraising. In conjunction with a fundraising endeavor, we may contact an individual.
- To Alert a Serious Threat to Health or Safety. In the case of a serious threat to health or injury of an individual or others in general, PHI may be disclosed as a method of prevention.
- Military and Veterans. PHI may be released about members of the armed forces as required by military authorities. Similarly, appropriate military authorities may receive PHI about foreign military personnel.
- National Security and Intelligence Activities. PHI may be disclosed to federal intelligence agents, counterintelligence, and lawful authorized security activities.
- Protective Services for the President and Others. To conduct a special investigation, or protect the President, foreign Heads of State, or authorized persons, PHI may be disclosed to authorized federal agents.
- Victims of abuse, neglect, or domestic violence. If abused, neglected, or domestic violence is suspected, PHI may be released to the appropriate government authority, such as protective services or social service agency. PHI will only be disclosed to the extent required by law if the victims agree with the disclosure, the disclosure is allowed by law, will not be used against the victim, and is deemed necessary by the public agent receiving the report or the avert serious harm to an individual.

CHANGES TO THIS NPP

We reserve the right to change this NPP as well as our privacy and procedures. When we do, we may make the changed NPP effective for medical information we already have about you then, as well as any information we receive in the future. You may also request an updated copy of NPP at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Department of Health and Human Services. All complaints must be submitted in writing. There will be no retaliation for filing a complaint. If you have any questions about this NPP or a complaint, please write to:

Complete Infusion Care, CIC, Inc. 2310 South Sepulveda Blvd. Los Angeles, CA 90064, Attn: Privacy Officer:

mhouske@completeinfusioncare.com

Dated: _____

Signature: _____

Guardian Signature: _____

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TEL# (310)836-6666 FAX# (310)836-6675

OUT OF NETWORK RELEASE OF PAYMENT AGREMENT

DATE: _____

PATIENT NAME: _____

INSURANCE: _____

ADDRESS: _____

RE: Authorization to release Out of Network Benefit payments to Complete Infusion Care, CIC Inc.
2310 South Sepulveda Blvd. Los Angeles, CA 90064

Claims Department:

I _____, give permission when applicable, for my insurance company listed above to released payment directly to Complete Infusion Care, CIC, Inc. for services rendered to me. I also hereby authorize Complete Infusion Care to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my care.

This authorization is given voluntarily and I hereby acknowledge that no guarantee has been made to me as to the results of the treatment given by Complete Infusion Care, CIC Inc.

_____ _____

Signature **Date**

_____ _____

Guardian Signature: **Date:**