Patient Consent Agreement and Acknowledgment

Patient Name: _____

Thank you for choosing WellDyne Specialty Pharmacy, we look forward to serving your specialty pharmacy needs. As a pharmacy, we have an obligation to provide quality care, stay in compliance with all laws and regulations, protect your personal health information, and perform services as you direct. In order to meet those obligations, we are required to obtain your consent for some of the services that we may offer and provide disclosures to keep you informed of your rights as a patient when using our pharmacy at (800) 641-8475.

By signing the acknowledgment below, you are indicating that we have provided you these disclosures, and that you are consenting to receive pharmacy services as a patient of WellDyne Specialty Pharmacy. Please note that each patient and therapy is different, and that not all terms will apply or be relevant to your situation. If you have any questions or concerns about these terms, please contact WellDyne Specialty Pharmacy.

1. **Medical Consent to Services**
   You have a right to choose the pharmacy you use to receive your prescriptions and professional services, which may include consultation with pharmacists and nurses. By signing this Agreement & Acknowledgment, you are agreeing to receive pharmacy services from WellDyne Specialty Pharmacy and our pharmacists and nurses. While providing services, you authorize WellDyne Specialty Pharmacy to work with your other healthcare providers on your behalf.

2. **Release of Medical Records and Insurance Information**
   I authorize the release of any medical or other information necessary to provide therapy, services, or products. I also request payment of government benefits either to myself or to the third party who accepts assignments according to the section below titled “Assignment of Benefits.”

3. **Financial Responsibility**
   I understand that if no insurance coverage exists for a product or service or the insurance provider fails to pay, I am financially responsible for the incurred charges. If a pump or pole is part of therapy received, all leased, loaned, or rented pumps and poles furnished by WellDyne Specialty Pharmacy remain the property of WellDyne Specialty Pharmacy. I am responsible for the replacement cost of lost, stolen, and/or damaged pumps.

4. **Assignment of benefits**
   If the product or services provided are payable under a Medicare or other applicable government or commercial provided benefit, I authorize payment and medical benefits to WellDyne Specialty Pharmacy for the therapy, services, and products supplied by WellDyne Specialty Pharmacy.

5. **Personal representative**
   I authorize WellDyne Specialty Pharmacy to disclose and provide information regarding treatment, therapy, payment issues, and health related issues to the person(s) listed below as patient’s personal representative(s):

   Name: _____

   Relationship: _____

   Phone: _____

   Name: _____

   Relationship: _____

   Phone: _____

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6. **Medicare Prescription Drug Coverage and Your Rights**
7. **Medicare DMEPOS Standards**
8. **Patient Rights and Responsibilities**
9. **Notice of Privacy Practices**
10. **Emergency Preparedness** - please see attachment

Only complete section 11 below if you will receive nursing services from WellDyne Specialty Pharmacy.

If not, skip to section 12 Acknowledgment of Receipt Form.

11. Advance Directives:

WellDyne Specialty Pharmacy is required by certain state pharmacy regulations to provide you with information about advance directives and your rights. Advance directives communicate what you want if you cannot speak for yourself, taking the burden off your family. When you have advance directives, your family and doctors know what treatments you do and do not want. If you receive nursing services from WellDyne Specialty Pharmacy, you can share information about your advance directives with us so that we know your treatment preferences if you cannot speak for yourself. WellDyne Specialty Pharmacy will not withhold services if you do not share your advance directives with WellDyne Specialty Pharmacy.

Advance directive acknowledgment:

I further acknowledge that I have been given an explanation of the rights under my state law to accept or refuse medical treatment and my right to formulate advance directives regarding such. I understand I am not required to have an advance directive in order to receive care from WellDyne Specialty Pharmacy. I understand that I may request and will be presented with, written material regarding formulating an advance directive if so desired. I agree to provide WellDyne Specialty Pharmacy with a copy of the executed advance directives. I will inform WellDyne Specialty Pharmacy of changes to any such advance.

I have executed the below documents, if applicable (please check all that apply):

- Living will
- Advance directive
- Medical durable power of attorney
- Appointment of surrogate
- I do not have an advance directive
- I would like information regarding formulating an advance directive specific to the state of _____

12. Acknowledgment of Receipt Form:

Patient signature (or legal guardian or parent): _____ Date: _____

Patient relationship: _____

Print name of signatory: _____

Only Necessary for Advanced Directive: _____

Witness signature: _____ Date: _____

Patient relationship: _____