LUX INFUSION
HEALTH. TEAM. EXCELLENCE

Patient Consent

1. CONSENT TO INFUSION THERAPY, MEDICAL CARE AND TREATMENT

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 LUX Infusion Centers and its associated physicians, providers, nurses, and clinicians. I understand that in many instances the clinicians are carrying out orders from my referring healthcare provider. Though 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 the Infusion Center 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 the Infusion Center is exposed to my blood or body fluids, I will be tested for the 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 the exposure.

2. CONSENT TO TREATMENT IN AN OPEN TREATEMENT AREA

I acknowledge and understand that the infusion center provides infusion therapy and medical care in a semi-private treatment environment. Despite safeguards and using reasonable care it is always possible in the infusions Center that I may learn information regarding other patients, or they may inadvertently learn something about me. In all cases, the Infusion Center expects and requires that its patients maintain strict confidentiality of any inadvertently disclosed health information of others.

3. CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD

I authorize the Infusion Center to photograph, videotape, or record me and agree that the images, video, or recordings may be used for medical reasons (including training, education, or research). I hereby release the Infusion Center, its employees, Clinicians, and other authorized persons from any responsibility which might arise from the taking and authorized use of such images, video, or recordings.

4. CONSENT TO USE INFORMATION

Electronic Health Records. I understand that the LUX Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices.

Use of Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organization, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinician's, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses, and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

Request for Information from Others. I consent to Infusion Center'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, for the uses described above, and LUX Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

5. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Infusion Center's Notice of Privacy Practices, which provides information on how the LUX Infusion Center may use or disclose my health information.

6. ASSIGNMENT OF BENEFITS

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

7. FINANCIAL RESPONSIBILITIES

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance of health care benefits, including any and all products (e.g. medications) provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered products and non-covered services also may include those products and services the Infusion Center and the Clinicians initially determine to be medically necessary but are later determined unnecessary or denied by my insurance or payer.

8. PERSONAL VALUABLES

I understand that LUX Infusion Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

Patient Name: _____ Patient Date of Birth: _____

Patient Address:

Street Address: _____

City: _____

Zip: _____

X _____ _____
Patient Signature or Legal Representative Signature Today's Date

If Signed by Legal Representative, Relationship to Patient
(e.g., parent, spouse, etc.)

_____

(Print Name and Provide Relationship)