I acknowledge that I have received the Consent/Assignment of Benefits Information from Infuserve America, Inc. and I agree to all the provisions stated therein. I understand that I am responsible for all deductibles, co-insurances, and co-payments determined by my insurance. I understand that Infuserve America is a self-pay pharmacy. I understand that copay is collected when I place my order. I hereby authorize Infuserve America to bill my insurance as a courtesy. I also understand that in the event my insurance reimburses less than what I have paid to Infuserve as my copay, Infuserve America will not back bill me for the difference.

I further acknowledge that I have received the Notice of Privacy Information and Patient Bill of Rights from Infuserve America, Inc. Should my shipment require it for international customs processing, I agree that my prescription will be available on the outside packaging for custom agent's review.

I understand that if I have any grievance, I should contact Infuserve America at any time and I have the right to a prompt resolution. If I am not satisfied, I may contact their accrediting body, ACHC to report my dissatisfaction.

I □ **allow or** □ **do not allow** voicemail messages to be left at the telephone numbers provided to Infuserve.

I □ **allow or** □**do not allow** Infuserve to speak to whomever may answer the telephone at the numbers provided if I do not answer the call.

I authorize the use of this signature on all insurance submissions, and a photocopy of this form will be considered as valid and effective as the original.

Patient Name_____

Signature_____Date_____

****

If the patient is unable to sign or is a minor, signature may be provided by the patient's agent below.

Reason patient is unable to sign:

_____

Signature of Patient's agent _____Date_____

Name_____Relationship_____