Penn Medicine | Penn Home Infusion Therapy

GENERAL CONSENT FORM

Patient Name:_____ **Patient DOB:** _____ **Penn MRN:** _____

Thank you for choosing Penn Home Infusion Therapy (PHIT). Penn Home Infusion Therapy is a licensed retail pharmacy that is part of the Hospital of the University of Pennsylvania and the University of Pennsylvania Health System. The Health System is part of Penn Medicine and the University of Pennsylvania. PHIT provides home infusion pharmacy services and related nursing care.

I have read and understood each paragraph below, and by signing give consent voluntarily. This consent further certifies that I have received information related to: the services offered by PHIT; PHIT's on-call system; the procedure to voice a grievance; and the mechanism to access information regarding my plan of treatment.

If signing electronically: I accept and I intend the signature(s) below to be legally binding and the equivalent of my handwritten signature.

Patient Signing:

Patient Printed Name	Patient Signature	Date	Time

Legally Authorized Representative Signing:

Print Name	Signature	Date	Time

Relationship to Patient

Penn Medicine Representative Signing:

Print Name	Signature	Date	Time

CONSENT TO CARE: I present myself for care by PHIT. I voluntarily consent to care including routine tests and treatment. I know that no guarantees have been made to me about the results of the care provided. I understand that Penn Medicine is part of the University of Pennsylvania, which is a teaching institution. I agree that those in training programs may take part in my care. I understand that for the purpose of my care, certain of my tissue(s), bodily substances and/or fluids may be removed and used, modified, disposed of, or transferred by Penn Medicine. I agree that any remaining tissues(s), bodily substances, and/or fluids may be used for education and research not specifically related to my care. If such material identifies me, research use will occur only with my permission. I understand that video, audio, and/or digital recordings/images of my treatment by Penn Medicine may be taken, and may be used for:

- Quality improvement and education, in which case the recordings/images will not become part of my medical record and will be erased after review. I have the right to decline the recording or image collection or its use for purpose of quality improvement and education; and
- Consultative services and treatment by healthcare providers at a distant site, such as another hospital, authorized by Penn Medicine, which may include interactive video, audio, and telecommunications technology (also known as "telemedicine"). Details of my health history, examinations, x-rays, tests and medical records may be reviewed by and discussed with these other healthcare providers at these distant sites and other hospitals.

CONSENT TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION: I understand and consent that Penn Medicine is permitted to use and disclose health information about me in any form for **treatment, payment, and healthcare operations** and as otherwise allowed by law. This includes sharing my health information with:

- Penn Medicine or outside providers involved in my care, and family members or friends involved in my care.
- Individual or parties responsible for payment for the care I receive, such as insurance companies, managed care companies, government programs and agencies such as Medicare, and each of their agents or auditors.
- I further consent and authorize PHIT to release to the Centers for Medicare and Medicaid Services (CMS) or its agents, any information contained or included in the Outcomes and Assessment Information Set (OASIS).

SPECIFIC CONSENT TO USE AND DISCLOSE SPECIAL RECORDS: I understand that Federal and state law specially protect health information and records relating to treatment for mental illness, HIV or AIDS, and/or drug or alcohol abuse ("Special Records"). Such laws allow Penn Medicine to use and share Special Records for my care and treatment and for other specified purposes and, in certain circumstances, require a special patient consent to release records.

Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES: I have been given a copy of Penn Medicine's Notice of Privacy Practices, which explains in more detail how my health information may be used and/or disclosed.

PATIENT RIGHTS AND RESPONSIBILITIES: I have been informed of the Patient Bill of Rights and Responsibilities that explains my rights and responsibilities as a patient in a language and manner that I understand and a copy has been made available to me. Penn Medicine provides translated Patient Bill of Rights and Responsibilities to assist patients and families on its website, http://www.pennmedicine.org/for-patients-and-visitors/patient-information/patient-rights-and-safety/patient-rights and language interpretation services are available, as needed.

ASSIGNMENT OF BENEFITS: In exchange for the care and services I am receiving from Penn Medicine, I hereby give and assign to Penn Medicine, including its Hospitals and providers and PHIT, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called an "assignment of benefits" and that Penn Medicine, its Hospitals, PHIT and/or providers may be called my "assignees." I agree that they can sue anyone in their own names as my assignee and obtain payment for charges relating to my care and payment for lawyers' fees resulting from collection efforts. I understand that I may be required to pay for charges for my care that others do not pay on my behalf.

MEDICARE BENEFITS: I request that payment of Medicare benefits be made on my behalf to PHIT, Penn Medicine, the Hospitals or their providers for any care or services provided to me. I authorize them to give the Centers for Medicare & Medicaid Services and its agents any information about me (or the person I signed for) needed to determine Medicare benefits. I have provided accurate information about Medicare secondary payors.

FINANCIAL RESPONSIBILITY: Even if I have insurance, I may be responsible for charges for my care that others do not pay on my behalf. I agree that within forty-five (45) days after Penn Medicine provides care to me (or the person I signed for), or the bill for such care is given to me or whomever is responsible for payment, I will pay Penn Medicine any unpaid charges. If the matter is sent to a collection agency or lawyer for collection, I will pay the outstanding charges and all lawyers' fees and collection expenses.

RIGHT OF SUBROGATION AND LIEN: I understand and agree that PHIT, Penn Medicine or its providers are "subrogated" to (substituted for me) and have the right to recover from any person or company legally responsible (whether by contract, tort, or some other way) for paying the charges for care provided to me. Also, if I make a legal claim against any person or company for compensation for the injuries or illness for which I am being treated, I agree that, to the extent permitted by law, Penn Medicine shall have a "lien" against (right to) any money I recover and I direct that any lawyers representing me pay this lien from the funds recovered before they distribute any funds to me. This right of subrogation and this lien will not include any money already paid to Penn Medicine. I agree to take, and to assist Penn Medicine in taking, whatever action is necessary to protect their subrogation rights (rights of substitution) and liens.

SEVERABILITY: If any part of this consent form is declared to be invalid, illegal or unenforceable, the rest of this consent form will not be invalid. This does not take away any rights I, my employer, or my insurance company may have under any existing contracts with Penn Medicine, or any statutory rights I may have.

PHARMACY COUNSELING: I have been given a printed copy of information related to the medication I am receiving. I understand that I may request to speak with a pharmacist to answer any questions I may have by calling PHIT at 1-800-666-6002.

ADVANCED DIRECTIVES: I have received and reviewed information regarding my right to accept or refuse medical treatment and of my rights to formulate Advance Directives. I understand that I am not required to have an Advance Directive in order to receive medical treatment and that the terms of any Advance Directive that I have executed will be followed by PHIT and my caregivers to the extent permitted by law.

- ☐ I have executed an Advance Directive and provided a copy.
- ☐ I have executed an Advance Directive and have not provided a copy.
  I understand that PHIT may not be able to implement this directive unless a copy is provided.
- ☐ I have not executed an Advance Directive

RESUSCITATION: I have received information about resuscitation (making my heart start to beat again and/or making me breathe again) and at this time, I have decided that **I DO**_____ or **I DO NOT** _____want resuscitation.

I have designated a Durable Power of Attorney for Healthcare. That person is:

_____

Name/Relationship **Phone #**

_____

Email Address