INFORMED CONSENT
UAB SPECIALTY PHARMACY AND THE KIRKLIN CLINIC PHARMACY

I understand that I am to receive my therapy at home or through UAB Outpatient Services. My medication(s) and supplies will be provided by the UAB Specialty Pharmacy or The Kirklin Clinic Pharmacy, I and/or my caregiver have been trained in the care and techniques for use associated with my access device, equipment, and medications, or arrangements have been made for my treatments to be administered by a trained professional. I have been provided a schedule for administration of my medication, and I have been instructed on how and when to request supplies, if needed.

Possible side effects of my medication(s) and therapy have been explained to me. I have been instructed on how and to whom to report unusual signs and symptoms. I have also been instructed on how to report problems associated with equipment or supplies.

If I should require home nursing care and/or laboratory testing, I have been informed of available services. I have also been informed that I may choose a pharmacy or home infusion service other than UAB Specialty Pharmacy or The Kirklin Clinic Pharmacy.

I understand that I must provide a means of communication, usually by telephone, so that my progress can be monitored. I must provide an address or arrange for pick-up of medications and supplies from the pharmacy location.

DISCLOSURE OF INFORMATION

I agree that the results of my treatment, including laboratory tests may be communicated to health-care providers associated with my care. I also understand that my medical record may be reviewed by medical students, pharmacy students, accreditation body representatives and regulatory inspectors as a part of normal operating procedures and quality improvement activities.

I authorize the pharmacy staff to review my medical history, prescription formulations, and insurance information as they relate to my care. This information will be solely used on my behalf for the purpose described. This information is not to be made available for any other use without my written consent.

ASSIGNMENT OF BENEFITS

I authorize payment of prescription and medical benefits to UAB Specialty Pharmacy or The Kirklin Clinic Pharmacy, for services rendered. I further agree to pay all charges connected with this treatment not covered by any insurance I may have and understand insurance coverage does not release me of the obligation of payment to UAB Specialty Pharmacy or The Kirklin Clinic Pharmacy. If unable to pay for services rendered, it is my responsibility to arrange counseling through Social Services and receive information on available options. I will receive an invoice or receipt for each delivery. My original signature will be on file granting consent for the continuation of my therapy.

If a Medicare patient, I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

If I have any questions pertaining to my treatment the pharmacy staff will be glad to answer them. If I have any medical emergencies, I have been instructed to contact my physician through UAB Hospital paging (telephone number 205-934-3411). Pharmacy-related emergencies should be directed to UAB Hospital paging (205-934-3411) and they will contact the pharmacist on call.

I have received a copy of this informed consent and rights & responsibilities. My signature below indicates that I agree to receive services from the UAB Specialty Pharmacy or The Kirklin Clinic Pharmacy.

Signature of Patient / Caregiver	Relationship	Date

Signature of Pharmacist		Date

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

UAB Specialty Pharmacy & The Kirklin Clinic Pharmacy

As a patient, you shall have the RIGHT:

1. To receive considerate, respectful and compassionate care regardless of your age, gender, race, religion, culture, language, disabilities, socioeconomic status, sexual orientation, or gender identity or expression.
2. To be provided with effective communication and receive information in a manner that is understandable and have access to sign or foreign language interpreter services. We will provide an interpreter as needed.
3. To speak with a health professional and to be provided with the names and titles of the staff members involved in your care. You have the right to speak with a staff member's supervisor, if requested.
4. To receive care in a safe environment, free from all forms of abuse, neglect or harassment.
5. To expect full consideration of your privacy and confidentiality in care discussions and treatments.
6. To know that our mission is to help you better understand your specific condition so you can achieve best results and maintain optimal health over the long-term through our patient management program. You also have the right to receive information about the care and services rendered to you through the patient management program and to be provided with information about your condition as it relates to the care provided. In addition, you have the right to receive information about changes in, or termination of, the patient management program.
7. To participate in decisions about your care, treatment and services provided, including the right to refuse treatment, decline participation, revoke consent and/or request another pharmacy or home infusion provider at any point in time .
8. To be involved in your individualized plan of care. This may include, but not be limited to, development and revision of plan of care, assessing pain and pain management, making care decisions and resolving dilemmas or ethical issues about care decisions.
9. To receive financial information as a result of your treatment, care, and services received, including financial counseling resources.
10. To expect that all communications and records about your care are confidential, unless disclosure is allowed by law. You have the right to see or get a copy of your pharmacy or home infusion records and have the information explained, if needed. You have the right to request amendment to, and/or receive a list of to whom your personal health information was disclosed.
11. To voice complaints about the care you receive and recommend changes freely without being subject to coersion, discrimination, reprisal, or unreasonable interruption in care.

Patient's RESPONSIBILITIES:

1. You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required. You have the responsibiluty to notify the pharmacy staff if your address changes.
2. You are expected to remain under the care of a licensed physician for the duration of your treatment course and inform the pharmacy staff if you decide to change physicians during the course of therapy. In addition, you have the responsibility to submit any forms that are necessary to participate in the patient management program.
3. You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks, changes in your condition and/or hospital admissions. You have the responsibility to notify your treating provider of your participation in the patient management program, if applicable.
4. You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your healthcare provider. You are responsible for outcomes if you do not follow the care, treatment and services plan.
5. You are expected to provide feedback about your expectations and satisfaction with the care and services provided.
6. You are expected to treat all staff, other patients and visitors with courtesy and respect.
7. You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner. You also have the responsibility to contact the pharmacy staff if your insurance changes.
8. When home care services are utilized, you are expected to keep home care visit appointments, or to call your home health care provider if you cannot keep your appointments.