Amber PHARMACY
888.370.1724

Patient Information Checklist

Please complete this form and return it to Amber Pharmacy *within 10 days*. A self-addressed, postage-paid envelope is included in this package for your convenience.

Patient Name: _____

Please check the applicable boxes below acknowledging receipt of medication, supplies, services, and/or equipment.

☐ Medication ☐ Supplies ☐ Equipment ☐ Services

Please review the following documents included in your New Patient Folder.

- Patient Information, Patient Complaints, Patient Rights and Responsibilities *(See Separate Insert)*
- HIPAA Privacy Notice *(See Separate Insert)*
- Medicare Supplier Standards *(See Separate Insert)*

Please read the following statements and check the appropriate box (Yes or No) for each item.

Acceptance of Services ☐ Yes ☐ No

I understand that by signing this agreement, I authorize provision of products and/or services to me by Amber Pharmacy. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

Same or Similar Equipment or Supplies ☐ Yes ☐ No

If "No" is checked, I acknowledge that I have never received the same or similar equipment or supplies from another home medical equipment provider. If I have selected "Yes", then I understand that my insurance carrier may not cover the supplies or equipment and I may be asked to execute an Advance Beneficiary Notice.

Release of Information ☐ Yes ☐ No

I hereby authorize release to Amber Pharmacy any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize Amber Pharmacy to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed.

Assignment of Benefits ☐ Yes ☐ No

I authorize direct payment of insurance benefits by my insurance company to Amber Pharmacy. In the event that my insurance carrier does not accept "assignment of benefits," I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Amber Pharmacy for payment of my bill.

Financial Responsibility ☐ Yes ☐ No

I understand that I am responsible to Amber Pharmacy for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay the rental and/or purchase price(s) of the items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by Amber Pharmacy for invoiced charges.

Please Turn Page Over to Continue

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Equipment Set-up and Instructions *(Only When Applicable)*

Please check the box next to each topic explained to you by an Amber Pharmacy representative.

- ☐ Assemble and install equipment
- ☐ Perform safety and operation checks
- ☐ Environmental and safety checks
- ☐ Assess risk of patient harm resulting from falls
- ☐ Demonstrate equipment and give verbal instruction to patient and caregiver
- ☐ Instruct alternate caregiver if appropriate
- ☐ Review printed educational materials, including printed safety precautions
- ☐ Physician's Rx for equipment use
- ☐ Patient's responsibility for routine maintenance, cleaning, infection control
- ☐ Amber Pharmacy address, phone, and business hours
- ☐ Delivery policy and follow-up policy
- ☐ Need to contact Amber Pharmacy if any change in patient status
- ☐ Procedure for non-operating equipment

Patient Health Information

Health Conditions

Please check the health conditions that apply to you.

- ☐ None
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Congestive Heart Failure
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Depression
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Multiple Sclerosis
- ☐ Organ Transplant
- ☐ Seizures
- ☐ Sinusitis
- ☐ Ulcer
- ☐ Other_____

Drug Allergies

Please check the drug allergies that apply to you.

- ☐ None
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Sulfa
- ☐ Penicillin
- ☐ Other_____

Medications

Please list all prescription and over-the-counter medications (i.e. aspirin, vitamins, antacids, dietary and/or herbal supplements) that you are taking. This information enables us to provide better assistance in helping you manage your medication therapy.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND REFERENCED DOCUMENTS, INCLUDING THE HIPAA PRIVACY NOTICE AND MEDICARE SUPPLIER STANDARDS.

Patient/Authorized Representative Signature: _____ Date: _____

Authorized Representative's Relation to Patient: _____