AcariaHealth™
Specialty Pharmacy

Foundation Care™
An AcariaHealth Solution

Specialty Therapeutic Care™
An AcariaHealth Solution

Assignment Agreement (Electronic/Major Medical)

1. **PATIENT RIGHTS AND RESPONSIBILITIES:** I have received and understand a list of patient rights and responsibilities.

2. **RELEASE OF INFORMATION:** I hereby authorize my insurer(s) and any other third party payer who provides coverage to disclose to AcariaHealth any information regarding such coverage, including but not limited to: payments made by such insurer(s) or third party payer(s) to me for services rendered to me by AcariaHealth and the scope and extent of coverage available from time to time. I authorize all medical personnel which may include but is not limited to: nursing agencies, physician offices, laboratory facilities, nursing homes, etc. to provide information to AcariaHealth concerning patient medical history as it may relate to my therapy. I consent to the review of my patient records by any Federal State, or Accrediting Body or Agency as required by Regulatory, Licensing, or Accrediting bodies.

3. **ASSIGNMENT OF BENEFITS:** I hereby authorize AcariaHealth to request on my behalf and to collect directly all public and private insurance coverage benefits due for supplies and services supplied by AcariaHealth. In the event payments for insurance coverage benefits are made directly to any of the undersigned, the payee will endorse to AcariaHealth all checks for such payments. In consideration of AcariaHealth's agreement to forgo collection of my account for a reasonable period of time, I hereby assign AcariaHealth or its legal representative all my rights, including the right to sue on my behalf or name under my insurance policy to recover charges for services rendered by AcariaHealth. This agreement shall not extinguish or diminish my obligation to pay the full fee to AcariaHealth for services rendered, but I shall receive credit for all sums collected pursuant to this agreement. If I enroll in another insurance plan, it is my responsibility to notify AcariaHealth, otherwise I will be responsible for payment.

4. **AGREEMENT TO PAY:** As AcariaHealth has agreed to supply me with any supplies and services ordered by me or on my behalf, I agree that I am responsible for payment for all such supplies and services provided to me. AcariaHealth has explained that my insurance will cover_____% of all the allowable amount and that I will be responsible for_____% plus any applicable yearly deductibles not met /co-payments which may amount to $_____total/per prescription. I am ultimately responsible for all charges not covered by his/her insurance.

5. **EQUIPMENT RENTAL:** I acknowledge that I am responsible for equipment such as IV poles, infusion pumps, or rental devices that are property of AcariaHealth. I warrant the safety and safe keeping of said property, including but not limited to loss, theft, fire, or other damages whatsoever. If the equipment is lost, stolen, or otherwise damaged while in my possession, I shall be liable for payment for the full purchase price of said equipment.

6. **CONTAINER CONSENT:** I hereby authorize AcariaHealth to dispense non-child resistant containers.

   YES ☐ NO ☐

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Patient Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

Relationship to Patient: _____

Please fill out this form and mail to:

AcariaHealth
8517 Southpark Circle, Suite 200
Orlando, FL 32819