Infusion Center of Pennsylvania

ICPA Patient Agreement

Patient Name:		Date of Birth:	

In anticipation of receiving infusion therapy as well as any other medically necessary treatment at the Infusion Center of Pennsylvania, LLC, ("ICPA") I agree as follows:

1. **Consent to Treatment**
   Understanding that infusion therapy entails certain medical risks, which have been explained to my satisfaction, and that there are no guarantees concerning the results of my treatment, I voluntarily consent to treatment by ICPA.

   I agree that if I do not follow the recommendations made by ICPA's staff as they may relate to my health and treatment, that neither ICPA nor any of its owners, employees, or staff may be held responsible for any injuries or damages that are the result of my non-compliance.

2. **How ICPA Works with Your Physician**
   I understand that ICPA does not diagnose any condition nor has any person associated with ICPA prescribed the treatment I am scheduled to receive; rather, I acknowledge that ICPA's role is solely to treat me, pursuant to the orders of my primary care physician, and the doctor(s) who have examined me and written my prescription (the "Referring Physician"). I acknowledge and agree that ICPA is not legally authorized to make medical decisions that are solely within the province of the Referring Physician nor is ICPA legally responsible for the acts or omissions of the Referring Physician.

3. **Release of Medical Information to ICPA**
   I request and authorize my Referring Physician and any other holder of medical information about me (including but not limited to medical history, family history, prescription history, inpatient and outpatient medical records, office notes and correspondence, and insurance information) or other information relevant to my care, whether written, verbal, or electronic, to release that information to ICPA, and I release anyone who does so from any obligations of confidentiality or other liability.

4. **Receipt of Notice of Privacy Practices**
   I acknowledge that I have received or been offered a copy of the **ICPA Notice of Privacy Practices** as required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I acknowledge that ICPA may use or disclose my Protected Health Information ("PHI") as described in that Notice.

   I understand that I may either (a) request additional privacy protections by ICPA or (b) authorize additional disclosures by following the instructions in that Notice.

I understand that I may withdraw or revoke any of the authorizations, understandings, agreements, or assignments made under this Agreement at any time by submitting a written notice of my desire to do so, but that such withdrawal or revocation shall have no retroactive effect.

By my signature I certify that I am the Patient named above or that I am duly authorized to execute this Agreement on the Patient's behalf.

x _____ _____

Signature Date Signed

_____ _____

Print Name Relationship to Patient