WILLIAMS BROS. HEALTH CARE PHARMACY

AGREEMENT AND CONSENT FOR SERVICES

(Authorization for Release of Information) (Assignment of Benefits and Deductible/Co-Pay Responsibility)
(Consent For Use And Disclosure Of Protected Health Information)

Patient Name: _____

Terms of Agreement and Consent for Specialty Pharmacy: I understand that by signing this agreement, I authorize provision of medications and services to me by Williams Bros. Rx Express (WB). I also understand that I am to remain under the medical care of my attending physician throughout the course of my treatment. The risks and benefits of medication services have been explained to me and I have been informed of my rights and responsibilities in the care process, and I fully understand them.
I understand that if I request additional services, not provided by WB Rx Express, they may refer me to another provider, which is not owned or operated by WB. In those cases, I will not hold WB responsible or liable for those services provided by another vendor, and will not hold WBHCP liable for furnishing me with the names of other home health care providers.
I understand that Williams Bros. will use and disclose my personal health information to treat my health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to occur, which are a part of the normal business activities of their organization.
I understand that Williams Bros. originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis/es and other health information to my bill(s).
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.

I understand that I have been provided with a Notice of Privacy Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by Williams Bros. Rx Express. I have the right to review the Notice of Privacy Practices prior to signing this consent. Williams Bros. can change its Notice of Privacy Practices, but must notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and that Williams Bros. is not required to agree to those restrictions. Any restrictions to which Williams Bros. agrees to will be respected. I may revoke this consent in writing at any time. I am aware that Williams Bros. can proceed with uses and disclosures that pertain to treatment, payment or healthcare operations that

took place before the consent was revoked. To request a restriction on the use and disclosure of your personal health information related to treatment, payment and healthcare operations, please do so after reading the Notice of Privacy Practices.

I request the following restrictions to the use or disclosure of my health information:

_____

Medical Information Authorization: I authorize my hospital, physician, or medical agency to provide WBHCP with any and all records, concerning my medical history, services rendered, or treatment received, as deemed necessary for treatment, payment and healthcare operations.

Release of Information: I hereby authorize the company to release any past and/or current health information as may be necessary for the coordination or continuation of my care to other service providers and to all third party payers, as required, to receive payment for services/equipment. I also authorize the review of my records including medical records by any Federal, state or accrediting body or agency. I also authorize that my records or circumstances surrounding my care be reviewed and utilized for Company quality improvement activities as long as my identification is not revealed outside the Company.

I hereby certify that I have read or have this document read to me and I understand its contents and intents, and with my signature, so execute my permission, effective as dated. I also certify that I am the patient or am authorized by the patient as the patient's general agent to execute the above and accept its terms.

Financial Information: In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Williams Bros. Rx Express, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from Williams Bros. Rx Express. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

Assignment of Benefits: I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Williams Bros. Rx Express any and all plan documents, insurance policy and/or settlement information upon written request from Williams Bros. Rx Express in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to Williams Bros. Rx Express to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from Williams Bros. Rx Express and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with Williams Bros. Rx Express in any attempts by Williams Bros. Rx Express to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with Williams Bros. Rx Express against such insurers and/or employee health care plan in my name but at Williams Bros. Rx Express expense (excluding Medicaid and Medicare plans).

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such as anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Patient or Guarantor Signature Date

_____ _____

Patient Representative Signature / Relationship Reason Patient Unable to sign

_____

Representative's Address