IF YOU ARE ON INFUSION THERAPY PLEASE READ THE INFO BELOW

1. **If I am an infusion patient,** I understand that there are additional risks associated with the use of intravenous medication and my physician has educated me about those risks. My physician has explained that there are risks, known and unknown, associated with the use of all medical equipment and supplies used with the administration of medication, and because I will be using the equipment and/or supplies at home, immediate emergency medical attention will probably not be available for any complication, injuries, or adverse results that may occur in connection with using the equipment or supplies. **I have been instructed to call "911" for emergency medical attention.**

2. **If my therapy requires an electronic or mechanical pump,** it will be sent and indicated on my delivery ticket and will be accompanied by an operating instruction manual along with information about any applicable warranties.

3. I acknowledge that I have received information, such as an equipment warranty information form, and/or a warranty information page in my operating instruction manual, about any warranties that may cover the pumps, devices, and other items supplied to me. Furthermore, the product is being sold or leased to me by **Pharmacy** as a service for my convenience. I understand that I am responsible for the replacement cost of lost, stolen, and/or damaged equipment.

4. I understand further that any and all representations regarding the equipment are the responsibility of the manufacturer and its authorized agents (including, but not limited to distributors and authorized service technicians). I have received instructions on the operating and related minor maintenance of the equipment and have read the operating instructions all of which are, in my opinion, adequate to enable me to properly operate it without direction of professional support staff at **Pharmacy**.

5. I understand that, to the maximum extent permissible under law, **Pharmacy** shall not in any event be liable for any consequential damages, secondary charges, lawsuits, or damages resulting from an alleged defect of the equipment or disposable supplies. A home health nurse may operate this infusion device and I will follow their instructions.

6. If I am a Medicare beneficiary, I understand that **Pharmacy** honors all warranties expressed and implied under applicable State law and will not charge me or the Medicare program for the repair or replacement of Medicare covered items (including all purchased and capped rental items and other rented items) or services covered under warranty.

I understand that I may contact the pharmacy at 1-888-292-0744 with any questions regarding this form.

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO THERAPY.

Patient Name ("Patient"): _____

Patient Signature: _____

Former/Alias/Maiden Name (If applicable): _____

Date of Birth: _____

Date: _____

Name of Personal Representative (If Applicable): _____

Signature of Personal Representative (If Applicable): _____

Description of Personal Representative's Authority: _____

BioPlus Specialty Pharmacy (FL) (HQ) 376 Northlake Blvd., Altamonte Springs, FL 32701
BioPlus Specialty Pharmacy (NC) 100 Southcenter Ct. Suite 100, Morrisville, NC 27560
BioPlus Specialty Pharmacy (CA) 13925 Yale Ave. Suite 145, Irvine, CA 92620
BioPlus PE Center 4751 Hamilton Wolf Road, San Antonio, TX 78229
MedScripts Medical Pharmacy 1325 Miller Rd. Suite K, Greenville, SC 29607
River Medical Pharmacy 4752 Research Drive, San Antonio, TX 78240
Route 300 Pharmacy 1208 Route 300 Suite 103, Newburgh, NY 12550
Santa Barbara Specialty Pharmacy 4690 Caprinteria Ave. Suite B, Carpinteria, CA 93013

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