

# The BioPlus Family of Pharmacies



## 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.** If I have questions after discussing this with my physician, I understand that I could ask a pharmacist additional questions. 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 understand that I should 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 will receive 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.

A copy of this form can be found at [bioplusrx.com/patientforms](http://bioplusrx.com/patientforms) and in your Patient Welcome Booklet.

**I understand that I may contact the pharmacy at the number on my prescription label 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: \_\_\_\_\_

Attach the appropriate documents granting legal authority to act on behalf of the patient.