**Accurate Rx Pharmacy**
103-B Corporate Lake Dr.
Columbia, Missouri 65203-7290
Office 573-256-4279 Fax 573-442-6429
Hotline 888-335-4279 info@accuraterx.net

## CONSENT FOR TREATMENT/ASSIGNMENT/RELEASE

I authorize the staff of Accurate Rx Pharmacy (ARx) to administer and/or perform the services, which have been prescribed, by my physician and his or her authorized representatives. I understand that ARx staff may include, in addition to ARx employees, persons with whom ARx may have contracts as independent contractors, under certain instances.

I confirm that I have been informed of the care and procedures to be carried out by the ARx staff. I sign this consent for treatment willingly and voluntarily, after careful consideration. I further understand that this consent is valid from the time of the initial visit by any ARx staff member, but that I may withdraw this consent at any time by written notice to ARx and, if I do so, ARx staff will no longer perform the services prescribed.

***RELEASE OF INFORMATION***

I hereby consent and request that my medical records be transmitted to ARx, if necessary, to permit the continuation of my health care plan. These medical records include, but are not limited to, information, reports or records concerning nursing care, therapy, laboratory analysis or medication provided to me or in regard to treatment. I authorize the release of such information, reports or records as are necessary to the coordination of my care plan to authorize professional personnel.

***ACKNOWLEDGEMENT OF HIPAA***

I hereby acknowledge that I have been provided with a copy of the "Notice of Privacy Practices" of ARx and have therefore been advised of how my protected health information may be used and disclosed by ARx and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of ARx. In addition, I certify that ARx can deliver to another specified location, other than my home, only upon my request.

***PHARMACIST COUNSEL***

By signing below, I hereby acknowledge that I have received written and have been offered verbal information from an ARx clinician concerning the therapy prescribed by my physician. I understand that to speak further with an ARx pharmacist about my prescribed therapy I may call 888-335-4279 at any time.

By signing below, I acknowledge that I have received, read and fully understand the Patient Drug Education Monograph associated with the services to be provided by ARx. I acknowledge that the Patient Drug Education Monograph discloses possible side effects related to the services to be provided by ARx. I acknowledge that I am fully aware of those side effects and voluntarily accept the risk that I may experience the side effects disclosed in the Patient Drug Education Monograph.

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I certify that I have read this form in its entirety and I agree with all statements set forth on this form. I further certify that I have reviewed ARx's mechanism for receiving, reviewing and resolving client complaints. To ensure the quality of home health care provided by ARx, you are encouraged to express your concerns or complaints freely. Please call ARX at 888-335-4279 or document your concerns on the satisfaction survey form. Your concerns will be responded to immediately.

**By signing below, I acknowledge that I have read this consent form in its entirety and fully understand the information herein.**