CONSENT FOR ASSIGNEMENT OF BENEFITS (AOB)

1. I wish to purchase health care products/medications and/or services from Infuserve America, Inc., a privately owned home infusion therapy company.
2. I attest that my home is suitable for home infusion therapy as I have running water, refrigeration, electricity and telephone.
3. I understand that my physician is solely responsible for diagnosing and prescribing drugs and therapy for my condition and otherwise supervising and controlling my medical care. I also understand that Infuserve America, Inc., services do not include diagnostic, prescriptive or other functions typically performed by a licensed physician.
4. I agree to hold Infuserve America, its employees, representatives, volunteers, team members and agents free from all liability, claim, loss, damage or expense of any kind that may arise out of or is in any way connected to my participation in this service, including any claims based on negligence, action or inaction of any of the above parties.
5. I hereby authorize my healthcare providers to furnish to an agent of Infuserve America, Inc. any records pertaining to my medical history, services, or treatment, as needed. I further authorize Infuserve America, Inc. to release any medical information to other parties or health agencies involved in my care, or any regulatory or accrediting bodies that may be surveying Infuserve America, Inc.
6. I hereby authorize Infuserve America, Inc. to furnish my insurance carrier(s) or its agent(s) any medical information concerning my medical history, services rendered or treatments, as needed to process claims. I understand that Infuserve America does not guarantee that my insurance will pay for my services, but they will bill my insurance company as a courtesy to me.
7. I assign and transfer to Infuserve America, Inc. all rights to receive any insurance benefits otherwise payable to me for products or services provided by Infuserve America, Inc. I authorize my insurance company(ies.) to furnish to any agent of Infuserve America, Inc. all information pertaining to my insurance benefits and status of claims submitted by Infuserve America, Inc. I understand I must sign the acknowledgement form, which allows my insurance company to make payments directly to Infuserve America.
8. Insurance payments are normally made within 30-60 days from time of billing. If my insurance company has not made payment within 60 days, Infuserve America will not take further action unless I specifically request it.
9. If any insurance carrier does not accept “assignment of benefits,” I understand that all correspondence and payments for Infuserve America, Inc. may be sent directly to me. I agree that when such payments are received, I will hold them in trust for Infuserve America, Inc. for payment of my bill.

10. I understand that I can make payment for services by either personal check, or by endorsing the insurance payment by writing “pay to the order of Infuserve America, Inc.”and my signature. In the event that the insurance payment is less than the outstanding bill, I understand that I will be personally responsible for the difference.
11. I also grant the right to Infuserve America, Inc. to obtain a copy of the insured’s policy from the insurer if necessary.
12. Should Infuserve be able to recover payment from my insurance, I understand Infuserve will reimburse me for corresponding payments I have made.