

## Patient Information Checklist

Please complete this form and return it to Hy-Vee Pharmacy Solutions *within 10 days*. A self-addressed, postage-paid envelope is included in this package for your convenience.

Patient Name: \_\_\_\_\_

Please check the applicable boxes below acknowledging receipt of medication, supplies, services, and/or equipment.

Medication       Supplies       Equipment       Services

Please review the following documents included in your New Patient Folder.

- Patient Information, Patient Complaints, Patient Rights and Responsibilities (*See Separate Insert*)
- HIPAA Privacy Notice (*See Separate Insert*)
- Medicare Supplier Standards (*See Separate Insert*)

Please read the following statements and check the appropriate box (Yes or No) for each item.

**Acceptance of Services**       Yes       No

I understand that by signing this agreement, I authorize provision of products and/or services to me by Hy-Vee Pharmacy Solutions. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

**Same or Similar Equipment or Supplies**       Yes       No

If "No" is checked, I acknowledge that I have never received the same or similar equipment or supplies from another home medical equipment provider. If I have selected "Yes", then I understand that my insurance carrier may not cover the supplies or equipment and I may be asked to execute an Advance Beneficiary Notice.

**Release of Information**       Yes       No

I hereby authorize release to Hy-Vee Pharmacy Solutions any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize to Hy-Vee Pharmacy Solutions to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed.

**Assignment of Benefits**       Yes       No

I authorize direct payment of insurance benefits by my insurance company to Hy-Vee Pharmacy Solutions. In the event that my insurance carrier does not accept "assignment of benefits," I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Hy-Vee Pharmacy Solutions for payment of my bill.

**Financial Responsibility**       Yes       No

I understand that I am responsible to Hy-Vee Pharmacy Solutions for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay the rental and/or purchase price(s) of the items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by to Hy-Vee Pharmacy Solutions for invoiced charges.

**Please Turn Page Over to Continue**

**Equipment Set-up and Instructions (Only When Applicable)**

**Please check the box next to each topic explained to you by a Hy-Vee Pharmacy Solutions representative.**

- |   |  |
|---|--|
| <input type="checkbox"/> Assemble and install equipment   | <input type="checkbox"/> Physician's Rx for equipment use  |
| <input type="checkbox"/> Perform safety and operation checks  | <input type="checkbox"/> Patient's responsibility for routine maintenance, cleaning, infection control |
| <input type="checkbox"/> Environmental and safety checks  | <input type="checkbox"/> Hy-Vee Pharmacy Solutions address, phone, and business hours                  |
| <input type="checkbox"/> Assess risk of patient harm resulting from falls                           | <input type="checkbox"/> Delivery policy and follow-up policy  |
| <input type="checkbox"/> Demonstrate equipment and give verbal instruction to patient and caregiver | <input type="checkbox"/> Need to contact Hy-Vee Pharmacy Solutions if any change in patient status     |
| <input type="checkbox"/> Instruct alternate caregiver if appropriate                                | <input type="checkbox"/> Procedure for non-operating equipment   |
| <input type="checkbox"/> Review printed educational materials, including printed safety precautions |  |

**Patient Health Information**

**Health Conditions**

**Please check the health conditions that apply to you.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> None                                  | <input type="checkbox"/> Cystic Fibrosis  | <input type="checkbox"/> HIV/AIDS           |
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Hypertension       |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Depression       | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Blood Disorder                        | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Organ Transplant   |
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> Sinusitis          |
| <input type="checkbox"/> Congestive Heart Failure              | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Ulcer              |
|  | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other _____        |

**Drug Allergies**

**Please check the drug allergies that apply to you.**

- |                                  |                                       |                                      |
|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None    | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa        |                                      |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin   |                                      |

**Medications**

**Please list all prescription and over-the-counter medications (i.e. aspirin, vitamins, antacids, dietary and/or herbal supplements) that you are taking. This information enables us to provide better assistance in helping you manage your medication therapy.**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND REFERENCED DOCUMENTS, INCLUDING THE HIPAA PRIVACY NOTICE AND MEDICARE SUPPLIER STANDARDS.**

Patient/Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative's Relation to Patient: \_\_\_\_\_