INFORMED CONSENT AND PATIENT ACKNOWLEDGEMENT

Printed Patient Name: _____ **Date of Birth:** _____

By signing below, I hereby authorize NuTech, Inc., and his/her authorized members of the healthcare team to administer and/or dispense the following medication(s):

_____

_____

CONSENT TO TREATMENT

I hereby authorize NuTech, Inc. to provide services/medications as prescribed by my prescriber. I understand that the purpose of these services/medications is to provide treatment for my illness, and I understand my overall treatment plan. The medication(s) and possible adverse reactions and events have been reviewed with me. I understand that not all adverse reactions discussed will occur. I confirm that I have been informed and have participated in planning my care and sign this consent willingly and voluntarily. I understand this consent is valid from the date of the start of initial therapy and I may withdraw my consent at any time by notice to NuTech, Inc. verbally or in writing. In the event I withdraw my consent, the services thereafter will not be provided.

If I am to receive intravenous medications (through my vein), I recognize that some of the medications may cause damage to my veins and surrounding tissues and may cause changes in their appearance, even when the medication is given properly. Some medications may cause drowsiness and fatigue and may impair my ability to drive or operate equipment. I am aware that I can contact my physician at the office for any questions I may have.

In signing this form, I indicate that I understand:

- The nature of the medications prescribed to treat my disease and the methods by which they will be given to me.
- The relative advantages, disadvantages, and risks associated with alternative treatment(s).
- The potential risks and hazards involved in the treatment my doctor has chosen for me, as explained.
- I have the right to refuse treatment, and the right to refuse to continue treatment after it has begun.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and transfer to NuTech, Inc., any and all rights to receive payment of insurance benefits. The assignment of benefits includes pharmaceuticals, durable medical equipment, supplies and professional services provided by NuTech, Inc. This assignment covers all benefits under Medicare, other state/federal government-sponsored programs, private insurance and any other health plans.

I understand this document is legally binding and is not simply an authorization to collect benefits on my behalf. I also authorize and direct my insurance carrier(s) to furnish an agent of NuTech, Inc., any and all information pertaining to my insurance benefits and the status of claims submitted by NuTech, Inc. for services rendered. I understand payments may be sent by my insurance provider directly to me. I agree when such payments are received, I will promptly submit them to NuTech, Inc. for payment of my bill. I can make payment by personal check or endorsement of the insurance

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payment by writing "Pay to the order of NuTech, Inc." and my signature. I understand I am also responsible for co-payments, deductibles and services not otherwise covered by my insurance carrier.

PAYMENT OF SERVICES RENDERED

I understand I am the responsible party for all medications and professional services rendered by NuTech, Inc. I understand that it is my responsibility to notify NuTech, Inc. of my insurance information including any changes in my insurance coverage.

I understand it is my responsibility to pay for any medications and services rendered which are not covered or are rejected by my insurance carrier, for whatever stated reason. NuTech, Inc. will provide products and/or services agreed upon at order coordination to the stated patient. As a courtesy, the estimated cost of each treatment will be communicated by NuTech, Inc. at the time of order coordination. I understand the amount may vary depending on deductible and out-of-pocket expenses. I agree to make payment arrangements at the time of order coordination.

ACKNOWLEDGEMENT OF RECEIPT OF MANDATED FORMS & NOTICES

By initialing and signing below, I hereby acknowledge receipt of:

_____ Patient Bill of Rights and Responsibilities
(initial)

_____ HIPAA Privacy Notice
(initial)

_____ Advance Directives information
(initial)

I agree to the terms stated in this NuTech, Inc., Informed Consent and Patient Acknowledgement document.

Patient Signature (or Representative): _____ **Date:**_____

Relationship to Patient (if Representative): _____ Is Patient a Minor? ☐Yes ☐ No

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