Client Consent Agreement and Acknowledgement

Thank you for choosing Cascade Hemophilia Consortium ("Cascade") to serve your specialty pharmacy needs. We provide quality care, comply with all laws and regulations, and protect your personal health information. We also obtain your consent for services provided and provide disclosures to keep you informed of your rights as a patient when using our pharmacy.

Client/Patient Document Acknowledgement
I acknowledge receipt of the following standard client/patient documents:

☒ Notice of Privacy Practices
☒ Client Rights and Responsibilities
☒ Cascade Guide for Families
☒ Important Delivery Information

Consent for Professional Services
I have a right to choose the pharmacy I use to receive prescriptions and professional services, which may include consultation with pharmacists. By signing this Client Consent Agreement and Acknowledgement, I agree to receive pharmacy services from Cascade and their pharmacists, employees, and contractors as a patient of Cascade. I authorize Cascade to work with my other healthcare providers on my behalf.

Release of Medical Records
By signing Cascade's Authorization to Disclose Protected Health Information, I authorize the release of any medical or other information necessary for Cascade to provide services or products to me.

Financial Responsibility
I understand that if no insurance coverage exists for a product I receive from Cascade or the insurance provider fails to pay Cascade, I am financially responsible for the incurred charges and I agree that the "Assignment of Benefits" section below does not release me from such responsibility. I further agree that I will pay all such incurred charges in accordance with Cascade's payment policies and procedures.

Assignment of Benefits

If the services and/or products provided are payable under a Medicare or other applicable government or commercial provided benefit, I assign all payments and medical benefits directly to Cascade for the products and/or services supplied by Cascade that would otherwise be payable to me. I understand that this "Assignment of Benefits" section imposes no obligation for Cascade to collect money on my behalf.

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My signature below evidences my agreement to all of the terms set forth in this Client Consent Agreement and Acknowledgement. I understand and agree that this Client Consent Agreement and Acknowledgement is effective on the date signed below until it is revoked by me in writing, which revocation shall be prospectively effective.

Patient Name: _____

Patient Signature (or legal guardian or parent): _____

Print Name of Above Signer: _____

Date: _____ Patient Relationship:_____