Patient AssistVI

ACCESSING MEDICATION FOR THOSE IN NEED.

PATIENT WAIVER

PATIENT HIPPAA AWARENESS

With my permission, Patient Assist VI, Inc., may use and disclose protected health information about me to carry out their mission of securing affordable medications necessary for my medical treatment. With my permission, Patient Assist VI, Inc. (PAVI) may call my home or other designated location that was provided on the point of contact form and leave a voice mail if necessary. If any contact information changes it is my responsibility to complete a new registration form. With my permission, Patient Assist VI, Inc. may mail to my home or other designated location that was provided, forms and or information that would assist PAVI in securing medication for me or that pertain to my case. With my permission, Patient Assist VI, Inc. may e-mail to my email address that was provided by me any items that pertain to my case and would assist PAVI in securing medication for me.

I have the right to request in writing that Patient Assist VI, Inc. restrict how it uses and discloses my protected health information. However, PAVI may not be able to assist me if restrictions are in place. By signing this, I am allowing Patient Assist VI, Inc. to use and disclose my protected health information for securing medications for me. I may revoke my consent in writing except to the extent that PAVI has already made disclosures in reliance upon my prior consent.

ACCEPTANCE OF REFFERAL AND WAIVER OF LIABILITY

By signing below, I authorize my physician to provide my personal information and medication list to Patient Assist VI so that they may determine eligibility for pharmaceutical assistance programs. I understand I will be contacted by a representative from Patient Assist VI, Inc.

I hereby release, for myself and on behalf of my successors and assigns Patient Assist VI, Inc., their officers, directors, employees and agents from all claims or liability arising from the use of the medication I receive from any all pharmaceutical patient assist programs. I acknowledge that Patient Assist VI is acting as a patient advocacy service. This service includes assistance with filling out application forms and sending them to appropriate pharmaceutical manufacturers in the hopes of securing free medication.

I acknowledge that this service does NOT include medical advice, and any questions regarding medication should be directed to my physician, any medication substitution must be approved by my physician. Furthermore, I acknowledge I have received and will receive NO medical advice from Patient Assist VI and that the information I have provided is truthful and accurate.

PATIENT CARING MEDICINE

Patient Name :

Patient Signature :

Patient Date of Birth:

Patient SSN:

Mailing Address :

E-mail Address :

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ENROLLMENT FORM

PERSONAL DATA INFORMATION

Full Name :

Place Of Birth : Gender : Male Female

Date Of Birth :
D D M M Y Y Y Y

Mailing Address :

Phone Number : City :

E-mail Address :

REFFERAL INFORMATION

PRIMARY CARE PHYSICIAN :

ANNUAL INCOME :

HOW MANY PEOPLE IN HOUSEHOLD (& RELATIONSHIP)? :

CAN THE REFERRED PERSON RECEIVE CALLS OR MAIL? : Yes No

HOW/WHEN IS THE BEST WAY TO CONTACT REFERRED PERSON? :

EMPLOYED? (PLEASE INCLUDE ANY INFORMATION RELEVANT TO EMPLOYMENT) : Yes No

MEDICARE RECIPIENT? : Yes No
(PLEASE INCLUDE AN INFORMATION ABOUT PART-D PRESCRIPTION INSURANCE AS KNOWN)

MEDICAID RECIPIENT? (M.A.P.)EVER APPLIED? : Yes No

PRIVATE MEDICAL/PRESCRIPTION INSURANCE? : Yes No
(IN MOST CASE PRIVATE INSURANCE WILL MAKE REFERRED PERSON INELIGIBLE)

ALLERGIES : Yes No

MEDICATION(S) + DOSAGE(S)

PATIENT CARING MEDICINE