Patient: ______________________________

AGREEMENT AND CONSENT FOR SERVICES FOR DIALYSIS CENTER

TERMS OF AGREEMENT AND MEDICAL CONSENT: I understand that by signing this Agreement, I authorize provision of products and/or services to me, by PHARMACY, as related to my IDPN infusion therapy.

I also understand that I am to remain under the care of my attending physician throughout the course of my therapy. The nature and purpose of the therapy, the risks involved, and the possibility of complications have been fully explained to me by my physician. I understand that the fluids and solutions being supplied to me were prescribed by my physician and not by PHARMACY.

I have been informed of my role in IDPN therapy, including the importance of participating in the planning of my care.

I have been informed that these products and services will be provided in a Dialysis Center rather than in a hospital. I understand that at any time I may go to the hospital if I feel it is necessary. I will contact my physician whenever I feel it is appropriate.

I have been informed of who to contact if I am dissatisfied with any of the care or service provided.

I hereby acknowledge that I have read and understand the above and have asked any questions that I may have had regarding the therapy and that if I have any further questions during the course of my IDPN therapy, I shall ask them.

I hereby consent to undergo such IDPN therapy:

NOTE: the undersigned certifies that he/she has read the foregoing and received a copy thereof. The undersigned also certifies that he/she is the patient, or is duly authorized by the patient's general agent to execute the above items.

Patient: ____ Date: ________________

Witness: ____ Date: ________________

Patient's Agent or Representative: Patient or Guardian: Date: ________________

____ Relationship: ________________

Fax completed form to (626) 585-8031

900 S Arroyo Pkwy. Unit #150 Pasadena, CA 91105

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