Optum Frontier Therapies™

Patient acknowledgment and informed consent to treatment

Patient name _____ Date of birth _____

Consent for treatment
I authorize Optum® Frontier Therapies to provide products, supplies and services as prescribed by my physician. I confirm I have been informed and have participated in planning my care. I sign this consent willingly and voluntarily.

I understand this consent is valid from the date of the start of therapy. I understand that I may withdraw my consent at any time by notice to Optum Frontier Therapies. If I do so, the services will no longer be provided.

Assignment of insurance benefits
I assign and transfer to Optum Frontier Therapies any and all rights to receive payment of insurance benefits. The assignment of benefits includes pharmaceuticals, durable medical equipment and, if needed, home health care, nursing and surgical benefits which are otherwise payable to me for products or services provided.

This assignment covers all benefits under Medicare, other state/federal government-sponsored programs, health insurance sponsored by private employers and any other health plans.

I understand this document constitutes a legally binding assignment, and is not a mere authorization to collect benefits on my behalf.

I also authorize and direct my insurance carrier(s) to give an agent of Optum Frontier Therapies any and all information related to my insurance benefits and the status of claims submitted by Optum Frontier Therapies for services rendered.

I understand payments may be sent by my insurance provider directly to me. If I receive those payments, I agree to promptly submit them to Optum Frontier Therapies for payment of my bill. I can make payment by:

- Personal check
- Endorsing the payment by writing “Pay to the order of Optum Frontier Therapies” and my signature

I understand I am also responsible for copayments, deductibles and services not otherwise covered by my insurance carrier.

Payment of services rendered
I understand I am responsible for arranging payments for all medications and services provided by Optum Frontier Therapies. I understand it is my responsibility to let Optum Frontier Therapies know my insurance information, including prescription card information.

I understand it is my responsibility to let Optum Frontier Therapies know of any changes in my insurance coverage.

I understand it is my responsibility to pay for any medications and services that are provided but are not covered or are rejected by my insurance carrier, for whatever stated reason.

Optum Frontier Therapies will provide products and/or services agreed upon when the order is coordinated for the stated patient. The estimated cost of each treatment will be communicated at 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.

Acknowledgment of receipt of notice of privacy practices
I hereby acknowledge receipt of the Notice of Privacy Practices concerning protected health information (PHI) from Optum Frontier Therapies.

Acknowledgment of receipt of mandated forms
I hereby acknowledge receipt of:

- Client Bill of Rights
- Medication refill and shipment process
- Infection control procedures
- Procedure for filing a grievance or complaint

I acknowledge receipt of the DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) Supplier Standards.

Product warranty/replacement information
Optum Frontier Therapies will honor all express warranties under applicable state law. Optum Frontier Therapies will not charge the beneficiary or the Medicare program for the repair or replacement of Medicare-covered items that are covered under warranty.

This applies to all purchase items. Please notify Optum Frontier Therapies at **1-855-768-9727** for any product that is broken or damaged, or does not properly function.

I have been instructed and understand the warranty/replacement information on the product I have received.

I agree to the terms stated in the Optum Frontier Therapies Patient Acknowledgment and Informed Consent to Treatment.

PATIENT SIGNATURE (or representative): _____ Date signed: _____

Relationship of representative to patient: _____ Is patient a minor? ○Yes ○No

Sign and return this document:

By mail: Optum Frontier Therapies
6425 Santa Margarita St. Unit 110
Las Vegas, NV 89118

By email: oft_privacy@optum.com

Important. Please sign and return.

Optum

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