

# CareIG Specialty Pharmacy

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## CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

### Patient Information

|                |  |
|----------------|--|
| Patient Name:  |  |
| Date of Birth: |  |
| Address:       |  |
| Phone:         |  |
| Physician:     |  |

### 1. Consent for Treatment

I authorize CareIG Specialty Pharmacy and its contracted nursing staff to administer intravenous immunoglobulin (IVIG) or subcutaneous immunoglobulin (SCIG) therapy in my home as prescribed by my physician. I understand that a registered nurse will perform the infusion and that I will be monitored during and after each visit.

I acknowledge that I have been informed of the potential risks and side effects of immunoglobulin therapy, including but not limited to: headache, fatigue, fever, chills, nausea, skin reactions at the infusion site, and in rare cases, anaphylaxis, renal dysfunction, or thromboembolic events. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

### 2. Financial Responsibility

I understand that CareIG Specialty Pharmacy will verify my insurance benefits and obtain any required prior authorization before scheduling my first infusion. CareIG will contact me with an estimate of my out-of-pocket costs prior to my first visit.

I agree to be financially responsible for any copayment, coinsurance, deductible, or non-covered charges as determined by my insurance plan after claims processing. I understand that the estimated cost provided before treatment is not a guarantee of my final responsibility, which is determined by my insurer.

If my insurance denies coverage or if I do not have insurance, I agree to be responsible for the full cost of treatment. CareIG will work with me to explore patient assistance programs if I experience financial hardship.

### 3. Release of Information

I authorize CareIG Specialty Pharmacy to share my protected health information with my prescribing physician, my insurance company, and any contracted partners involved in my care (including specialty pharmacies supplying medication and home health nursing agencies) for the purposes of treatment, payment, and healthcare operations, in accordance with HIPAA regulations.

### 4. Cancellation and Rescheduling

I agree to provide at least 24 hours notice if I need to cancel or reschedule an infusion visit. Failure to provide adequate notice may result in charges for nursing and supply preparation.

*By signing below, I confirm that I have read and understand the above, and I voluntarily consent to treatment and accept financial responsibility as described.*

|                                                         |  |             |
|---------------------------------------------------------|--|-------------|
|                                                         |  |             |
| <i>Patient Signature (or Authorized Representative)</i> |  | <i>Date</i> |

|                   |  |             |
|-------------------|--|-------------|
|                   |  |             |
| <i>Print Name</i> |  | <i>Date</i> |

|                                                    |  |             |
|----------------------------------------------------|--|-------------|
|                                                    |  |             |
| <i>Relationship to Patient (if representative)</i> |  | <i>Date</i> |

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Please sign and return to CareIG Specialty Pharmacy via email ([intake@careig.com](mailto:intake@careig.com)) or fax ((888) 555-0147).  
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