

CareIG Specialty Pharmacy

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

PATIENT INFORMATION

Patient Name:	Maria Elena Vasquez	Date of Birth:	03/15/1971
Address:	4821 SW 112th Avenue, Miami, FL 33165	Phone:	(305) 555-4892
Email:	m.vasquez1971@gmail.com	Case ID:	Vasquez_03151971
Referring Physician:	Dr. James T. Harrington, MD	Physician NPI:	1073541867
Diagnosis (ICD-10):	D83.9 Common Variable Immunodeficiency	Drug Ordered:	Privigen 10%, 35g IV q4w
Insurance:	Aetna PPO	Member ID:	AET847392018

1. CONSENT FOR TREATMENT

I, the undersigned patient (or authorized representative), voluntarily consent to the administration of intravenous immunoglobulin (IVIG) infusion therapy and any associated nursing services, medications, and supplies as prescribed by my referring physician. I understand that this therapy will be administered in my home or another approved site by licensed clinical staff employed by or contracted with CareIG Specialty Pharmacy.

I acknowledge that I have been informed of the nature of IVIG therapy, the purpose of the prescribed medication, potential risks and benefits, and available alternatives. I have had the opportunity to ask questions and receive satisfactory answers.

I authorize CareIG Specialty Pharmacy to communicate with my referring physician and other treating providers as necessary to coordinate my care.

2. FINANCIAL RESPONSIBILITY

I understand and agree to the following financial terms:

Insurance Assignment: I authorize CareIG Specialty Pharmacy to bill my insurance carrier(s) on my behalf and to receive payment directly from my insurer(s) for covered services. I assign benefits payable under my insurance policy to CareIG Specialty Pharmacy.

Patient Responsibility: I agree to pay any amounts not covered by my insurance, including but not limited to deductibles, copayments, coinsurance, and non-covered services. CareIG Specialty Pharmacy will contact me with an estimate of my anticipated out-of-pocket costs prior to scheduling my first infusion visit.

Insurance Verification: I understand that my insurance benefits will be verified prior to the start of therapy. I agree to notify CareIG Specialty Pharmacy of any changes to my insurance coverage, address, or contact information promptly.

Collection: I understand that if my account becomes past due, CareIG Specialty Pharmacy reserves the right to pursue collection of outstanding balances, which may include referral to a collection agency. I agree to be responsible for reasonable collection costs.

3. RELEASE OF INFORMATION / HIPAA AUTHORIZATION

I authorize CareIG Specialty Pharmacy to release my protected health information (PHI) to my insurance carrier(s), referring physician, and other treating providers as necessary for the purposes of treatment, payment, and healthcare operations, in accordance with applicable federal and state law (including HIPAA). This authorization remains in effect until revoked in writing.

4. PATIENT RIGHTS AND ACKNOWLEDGMENTS

I understand that I have the right to refuse treatment at any time. I understand that CareIG Specialty Pharmacy's Notice of Privacy Practices has been made available to me and that I may request a copy at any time. I acknowledge that I have received or have been offered a copy of this Notice.

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that providing false information may result in denial of services and/or legal action.

SIGNATURES

By signing below, the patient (or authorized representative) confirms that they have read, understood, and agree to all terms stated in this Consent for Treatment and Financial Responsibility form.

Patient Signature: Maria Elena Vasquez

Date: 04/01/2026

Printed Name: Maria Elena Vasquez

Relationship to Patient: Self

FOR CAREIG USE ONLY

Consent Received By:	Teresa Rodriguez (INT-003)	Date Received:	04/01/2026
Method:	Electronic (email — m.vasquez1971@gmail.com)	File Saved:	consent_signed.pdf