Beacon Infusion
Healthcare Services

Headquarters Location:
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CONSENT for TREATMENT

I, the undersigned, consent to the administration of (medication/s): _____
via (circle one method): injection intravenous infusion nasal spray
for the diagnosed condition _____ on (date) _____ .
Treatment location: _____

This treatment is prescribed by (ordering provider) _____, who has provided an order for the above treatment, and under whose care and medical decision making I am being treated for the above condition.
My referring provider has explained to me the nature and purpose of each medication with which I am being treated, as well as the risks and possible complications involved, the benefits, and the medically reasonable alternative methods of treatment. I have had the opportunity to ask questions regarding the treatment above and all of my questions have been answered to my satisfaction. I have read or have had read to me this consent form. I have had explained to me, and I understand the potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any medically reasonable alternatives, to my satisfaction. I have received no guarantees from anyone regarding the results that may be obtained from this treatment.
I have provided Beacon Infusion Healthcare Services LLC and/or its affiliates, partners and licensees with accurate information about my medical history and background to the best of my ability. I hereby release Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees, as well as their physicians, administration, staff, partners, vendors and affiliates from any responsibility for all consequences which may result from the aforementioned treatment.

HEPATITIS B VIRUS CONSENT

Particularly for patients taking medications which modulate their immune systems, including but not limited to Actemra, Cimzia, Orencia, Remicade, Rituxian, and Simponi Aria. If I have not had appropriate Hepatitis B Virus (HBV) vaccination, or should I refuse such vaccination, I understand that due to my exposure to potentially infectious material, I may be at risk of acquiring HBV, a very serious disease.

PREGNANCY AND BREASTFEEDING CONSENT

For Females: Please check one (1) of the following:

- ☐ I am not pregnant now and have no reason to suspect that I am pregnant. I am aware of the potential risks, known and unknown, to the fetus should I become pregnant during treatment, including miscarriage and/or congenital deformity. If I should become pregnant, I will notify the clinical staff immediately.
- ☐ I am pregnant, will continue treatment, and am aware of the potential risks, known and unknown, to the fetus, including miscarriage and/or congenital deformity.
- ☐ I am breastfeeding and will continue breastfeeding while receiving treatment. I am aware of the potential risks, known and unknown to my breastfeeding child while receiving treatment.

EMPLOYEE INCIDENT

In case of an employee needle-stick injury or exposure to my blood or body fluids, I consent to have any labs drawn by your clinical staff, including but not limited to, blood and urine, for testing for infectious diseases including Hepatitis and HIV.

My signature below indicates that I do hereby agree and consent to the above described treatment and to all the conditions above.

Patient Name (Please print clearly):_____

Signature of Patient: _____ Date: _____