**Patient Consent & Acknowledgment Form**

I authorize St. Matthews Specialty Pharmacy to provide pharmacy services, including dispensing prescribed medications, coordination of care with my prescriber and healthcare team and providing clinical services related to my medication therapy. I understand these services are provided under the supervision of licensed pharmacists and that I may refuse services at any time.

I understand that participation in St. Matthews Specialty Pharmacy’s Patient Management Program is voluntary and includes medication counseling and adherence support, side effect monitoring and education and coordination with my prescriber if therapy changes are needed.

I authorize St. Matthews Specialty Pharmacy to deliver my medications to my home address, my provider’s office or other location as indicated to the pharmacy. I authorize the pharmacy to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider.

I accept responsibility for securing medications upon delivery and notifying the pharmacy of any issues with receipt or storage. I understand that my signature below serves as the Patient Ship Authorization.

I authorize St. Matthews Specialty Pharmacy to contact me regarding my prescriptions, refills, clinical care, billing, delivery, and other pharmacy-related matters using any of the following communication methods: Phone, Text (SMS), Email, Secure Patient Portal. I understand that standard messaging rates may apply and that I may revoke or change my communication preferences at any time by notifying the pharmacy in writing or by phone.

I authorize the use and disclosure of my PHI to my prescriber and healthcare providers, my insurance or health plan(s), other persons or entities as required for coordination of care or reimbursement and third parties including Pharmacy Benefit Managers (PBM), distributors, or their agents. This authorization is valid for the duration of my therapy unless revoked in writing.

I authorize St. Matthews Specialty Pharmacy to contact my insurance provider(s) to obtain coverage information for my prescribed medications or services, submit claims to my insurance, Medicare, Medicaid, or any third-party payer on my behalf. And initiate and coordinate prior authorization requests and benefit investigations as needed for my prescriptions.

I understand that I am responsible for paying any co-pays, coinsurance, deductibles, or non-covered charges as determined by my insurance plan. If insurance denies coverage, I may be responsible for the full cost of the medication unless other arrangements are made. St. Matthews Specialty Pharmacy will notify me of any known out-of-pocket costs before shipping. I agree to pay any balances owed in accordance with the pharmacy’s billing and collections policy.

I understand that I have an offer for prescription counseling by a St. Matthews Specialty Pharmacy pharmacist and decline counseling at this time but understand that I may contact the pharmacy for counseling at any time in the future.

I have read and understand this form. I authorize St. Matthews Specialty Pharmacy to provide the services described above. I may revoke consent at any time, in writing, except where actions have already been taken based on this consent.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ I am signing on behalf of the patient as their authorized representative.

Name of Authorized Signer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Signer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_