Big Sky Managed Care Patient Infusion Packet
We are happy you are here!

Thank you for choosing Big Sky Managed Care as your infusion and specialty pharmacy provider. We provide home infusion therapy in the comfort of your own home and also provide a state-of-the-art private infusion suite with all of the comforts of home. Thank you for choosing us for your infusion needs and we look forward to serving you.

In order to provide services to new patients, we need a completed intake packet. Please provide as much information as possible so we can effectively communicate with everyone involved in your medical care. If certain information does not apply to you, please indicate that by noting "N/A" or "Not Applicable" so we know nothing was missed. If at any time during the course of your treatment, you are planning to move, your insurance(s) change or any other significant life changes occur, please contact us as soon as possible to ensure your services will not be disrupted.

Big Sky Managed Care is also able to provide medical supplies and pharmacy services throughout the state of Montana. We will coordinate delivery of these services conveniently to your home. If you are interested in any of these additional services, please call us. It is our goal to provide a one-stop, convenient service for all your pharmacy and medical needs.

Sincerely,

Your Big Sky Managed Care Infusion and Specialty Pharmacy Staff

Private Infusion Suite

Big Sky Managed Care Infusion and Specialty Pharmacy
900 13th Ave S
Great Falls, MT 59405

8:00 am – 5:00 pm
Monday through Friday by appointment only
406-315-1989
406-315-1988 (fax)

The Day of Your Infusion
On the day of your appointment, please arrive 15 minutes early. You will enter through the front door where you will be directed to your own private infusion suite.

Preparing for Your Infusion
Please be sure to drink at least 2 cups of water, bring your completed new patient forms included with this letter, a list of your current medications, insurance card, and copayment. Please wear comfortable clothes and dress in layers. You are welcome to bring a blanket and pillow, your laptop/tablet and whatever you might need to be comfortable and pass the time during your infusion.

What You Can Expect in Your Suite
You will get your own private suite in a relaxed setting for your specialty infusion or injection. Every patient has access to a comfortable recliner, room for a guest (12 years and older) and a couch for seating, a large screen TV with cable, wireless internet, snacks and beverages.

When to Cancel
Please cancel your appointment if you have a fever, infection, are on antibiotics, have yellow/brown/green drainage, or have had a live vaccine in the last 8-12 weeks. If you have any questions about whether you should receive your infusion, please contact your physician. If you need to cancel your appointment, please call at least 48 hours in advance to avoid a $50 cancellation fee. If you are more than 15 minutes late, you may be asked to reschedule.

Emergency
In the event of an emergency or reaction, please call 911 or contact your prescriber.

Big Sky Managed Care looks forward to caring for you. If you have any questions or concerns, please feel free to call us at 406-315-1989.

*** If receiving your treatments in our private infusion suite, please skip to page 7. ***

In-Home Infusion Therapy

Patient Copy

Big Sky Managed Care Infusion and Specialty Pharmacy
900 13th Ave S
Great Falls, MT 59405

8:00 am – 5:00 pm
Monday through Friday and on-call services after hours
406-315-1989
406-315-1988 (fax)

There may be two components to your infusion therapy: pharmacy and nursing. During your medication therapy, you may choose Big Sky Managed Care's trained infusion nurses to manage your care or you may receive nursing care from a clinic or home health agency nurse. Or you might be comfortable overseeing your own of health at home. In either case, our pharmacists and nurses will coordinate services to bring you optimal care.

Our staff will contact you during the course of your therapy to check in, ask how you are feeling, and see if you have questions or concerns regarding your therapy. We ask you keep inventory of your supplies; that way, if you become low, we are able to deliver refills before they are depleted. If you need supplies at times other than your scheduled deliveries please call us and we will attempt to expediate an order for an additional fee.

We encourage patients to call our staff at any time. Our office hours are Monday through Friday from 8:00 am to 5:00 pm. We also have a pharmacist on call 24 hours a day, seven days a week, to address any urgent questions or concerns that may arise. We suggest you have your physician's phone number close at hand, be familiar with the location of the closest hospital and emergency room and know that 911 should be called in the event of an emergency.

Please use the area below to write in important phone numbers:

Physician: _____ Phone: _____

Home Health Nurse: _____Phone:_____

IN CASE OF EMERGENCY CALL 911

Blood & Bodily Fluid Precautions

Patient Copy

Nurses and family members who care for patients receiving home intravenous therapies should be careful when handling blood and other bodily fluids.

Thorough hand washing before and after caring for the patient cannot be over-emphasized to protect both the patient and the caregiver from possible infections.

Some examples of bodily fluids:

- Stool
- Vomit
- Urine
- Saliva
- Sputum
- Mucus
- Blood specimens
- Blood
- Vaginal secretions
- Wound drainage
- Skin lesion drainage
- Semen

Follow these directions when caring for patients and handling blood and bodily fluids:

1. Wash your hands thoroughly before and after patient contact, even if gloves are worn.
2. While caring for the patient and handling patient equipment, do not touch your face or mouth.
3. Wear gloves when in direct contact with any of the patient's bodily fluids or blood.
4. Wear gloves when handling supplies that have been contaminated with a patient's blood and/or bodily fluids.
5. Wear a disposable gown when clothing is likely to be in contact with the patient's bodily fluids and a mask if recommended.
6. All disposable articles contaminated with blood and/or other bodily fluids should be disposed of in a sealed plastic bag.
7. Use household bleach to cleans spills and to wash soiled clothes and linens.
8. Do no bend, break or recap used needles.
9. Dispose of all used needles and syringes in a sharp's container.

If you received a sharps container:

DO NOT THROW AWAY YOUR SHARPS CONTAINER WITH NORMAL TRASH!

When your sharps container is about ¾ full, it needs to be replaced. Please cap the top of the container securely and bring to Big Sky Managed Care. We will properly dispose of your sharp's container free of charge.

PLEASE KEEP THE SHARPS CONTAINER OUT OF THE REACH OF CHILDREN.

Storage and Handling of Solutions

Patient Copy

When your medication arrives, store it immediately. Please organize your medication so the older solutions are used before the newer ones. **The expiration date of your medication is printed on the label attached to each unit of medication.**

Your medication is supplied as a solution in either bags or elastomeric balls (also called "Eclipses") made of strong plastic. However, they should be handled gently and protected from sharp objects.

Your solution may be delivered to you refrigerated, or frozen, depending on the medication. This is by design. If it comes to you refrigerated, keep it refrigerated and do not freeze. If it comes to you frozen, keep it frozen and do not refrigerated.

Storage and handling of REFRIGERATED solutions:

- Keep the refrigerator at a temperature of 36*F to 46*F.
- Place the medication solutions in an area of the refrigerator that will be less likely to freeze and away from food.
- Remove from the refrigerator only the number of bags and/or Eclipses you intend to use for your next dose.
- Before use, allow the medication to warm to room temperature, avoiding extreme heat and light. **The medication label contains information regarding when to remove the medication from the refrigerator before use.**
- The solution unit may be cool to the touch when ready to use. Keep in mind the time to reach room temperature depends on the medication, bag size and delivery device.
- Do not warm the solution by using water baths or other direct sources of external hear, like a microwave oven, direct sunlight or radiator. After warming, check the bag for leaks.
- Minimize the exposure of solutions to room temperature for an extended period of time.

Unless labeled otherwise, refrigerated solutions must be used within 24 hours once removed from the refrigerator. If this is not done, the medication must be discarded.

Storage and handling of FROZEN solutions:

- The freezer should be a temperature of -4*F to 14*F.
- Remove enough solution from the freezer to supply for 24 hours. Thaw the frozen solution bags at room temperature, 70*F to 74*F.
- When thawing, place the solution bags in an area protected from extreme heat and light.
- Do not thaw and warm the solution by using water baths or other sources of external heat, like a microwave oven, or direct sunlight
- After thawing, check the bag for leaks. Thawed solution bags should not be re-frozen.
- Thawed solution bags should be used within 24 hours after removal from the freezer.
- Once the solution has thawed, it must be then placed in the refrigerator until it is ready to be used.

DO NOT USE THE BAG/ECLIPSE IF:

- Any leaks are present. If there is any cloudiness, particles or specks that do not disappear with gentle mixing of the solution.
- The label on the bag/Eclipse does not have your name on it or has a different drug or dose listed.
- The expiration date on the label has passed.
- If any of these situations occur, please call Big Sky Managed Care at 406-315-1989 AS SOON AS POSSIBLE.

Review of Instructions

Patient Copy

Flushing with Sodium Chloride and Heparin is often needed if medications are to be separated from each other. This is often done by using the **"SASH"** method.

S	**SALINE (SODIUM CHLORIDE)**	(WHITE CAP ON SYRINGE)
A	**ADMINISTER MEDICATION**	
S	**SALINE (SODIUM CHLORIDE)**	(WHITE CAP ON SYRINGE)
H	**HEPARIN**	(YELLOW OR BLUE CAP ON SYRINGE)

Clean Technique

- Wash your hands and prepare a clean and dry surface on which to work.
- Do not have any animals, including cats and dogs, in work area.
- Prepare your supplies, such as gathering flushes and medications.
- Clean catheter end cap with alcohol.
- Attached medication tubing to clean catheter end cap, taking special care to protect both from dirty surfaces.
- Dispose of waste appropriately.

Signs and Symptoms to Report to MD/Nurse/Pharmacist

- Redness, swelling, pain, drainage or unusual lines near catheter insertion site.
- Dressing wet, soiled or coming off.
- Nausea, vomiting, diarrhea, constipation, fever, chills, and rash.

Storage of Medications

Unless instructed otherwise, all medications are stored in the refrigerator. Remove for administration 1 – 12 hours prior to dosing, as indicated on the medication label.

Additional Questions

Regarding medications and/or side effects, should be directed to the pharmacist at 406-315-1989 or the on-call number provided to you.

Patient Rights and Responsibilities

Patient Copy

Your Rights:

Respectful and Safe Care

- Be given considerate, respectful and compassionate care.
- Be given care in a safe environment, free from abuse and neglect (verbal, mental, physical or sexual).
- Know the names and jobs of the people who care for you.
- Have your culture and personal values, beliefs and wishes respected.
- Be given a list of protective and advocacy services, when needed.
- Ask for an estimate of charges before care is provided.

Effective Communication and Participation in Your Care

- Get information in a way you can understand and be involved in your plan of care.
- Involve your family in decisions about care.
- Ask questions and get a timely response to your questions or requests.
- Refuse care.
- Have someone with you for emotional support, unless that person interferes with your or others' rights, safety or health.
- Select someone to make health care decisions for you, if at some point you are unable to make those decisions.
- If an issue arises, your complaint will be reviewed without affecting your care.

Privacy and Confidentiality

- Have privacy and confidential treatment and communication about your care.
- Be given a copy of the HIPAA Notice of Privacy Practices.

Your Responsibilities

- Provide accurate and complete information about you.
- Call if you cannot keep your appointment.
- Be respectful of your Infusion Center team.
- Be considerate in language and conduct of other people and property, including being mindful of noise levels, privacy and number of visitors.
- Give us a copy of your advance directive.
- Ask questions if there is anything you do not understand.
- Report unexpected changes in your health.
- Take responsibility for the consequences of refusing care or not following instructions.
- Pay your bills or work with us to find funding to meet your financial obligations.

Concerns or Complaints

If you have concerns or are not satisfied with services provided you may lodge a complaint without fear of discrimination, reprisal or unreasonable interruption of service:

- Contact Big Sky Managed Care and we will notify you within five (5) calendar days of receiving your complaint.

Acknowledgment of Financial Responsibility

The client understands their insurance coverage may not pay the total cost of the medication, equipment, products or services provided by Big Sky Managed Care and/or its subsidiaries. The client acknowledges their obligation to pay the balance between what their insurance coverage will pay and what BSMC charges for medications, equipment, products or services.

The client further acknowledges they will be responsible to pay, within 60 days from the date the claim was submitted to their insurance, the full amount of charges associated with any medications, equipment, products or services they receive from BSMC, should their insurance deny payment for any reason, including, but not limited to; the clients failure to qualify for any medications, products or services; non-coverage by their insurance payer; or the clients failure to provide complete and accurate information to BSMC necessary for billing their insurance payer.

BSMC shall have the right to pick up all equipment if financial responsibilities are not met. The client authorizes BSMC to initiate a complaint to the Insurance Commissioner on their behalf. The client agrees to remit to BSMC any payments made directly to them by their insurance payer for medications or products provided by BSMC.

The client agrees to be responsible for their co-payment and/or annual deductible amounts. Statements are mailed monthly with payment due by the end of each month. Payments can be mailed or taken over the phone by our Accounts Receivable department.

We accept cash, personal checks, company checks, money orders and credit cards (VISA, MasterCard, American Express and Discover Card). We also make credit card pre-payment arrangements for anticipated monthly client balances. Beginning on the 61st day after billing, a $30.00 late fee may be added to the balance very month until the balance is paid in full. BSMC will be entitled to the full amount due on the account, including, but not limited to, attorney fees and/or collection fees that may accrue.

This agreement is binding as long as I am receiving medication, equipment, products or services FROM Big Sky Managed Care and/or its subsidiaries. The world "client" is understood to be the person receiving medication, medical equipment and/or supplies FROM Big Sky Managed Care and/or its subsidiaries.

_____

Client Name

_____ _____

Signature of Client or Client's Legal Representative | Date

_____ _____

Printed Name of Client's Legal Representative | Relationship to Client

Patient Consent for Treatment

1. **Consent to Infusion Therapy, Medical Care and Treatment**
   I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, and tests, provided by Big Sky Managed Care (BSMC) and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). I understand in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand if I do not follow my referring provider's or the Clinician's recommendations as they may relate to my health that BSMC and the Clinicians will not be responsible for any injuries or damages that are the result of my non-compliance. I understand if any employee or individual associated with BSMC is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand I will receive education related to this testing and I will not be charged for testing and education related to the exposure.
   Prescribed Therapy (Medication):_____ Physician: _____

2. **Hepatis B Virus Consent for Treatment**
   For patients on the following medications: Actemra, Cimzia, Inflectra, Orencia, Ocrevus, Renflexis, Remicade, Rituxan, Simponi Aria: If I have not had a Hepatitis B Virus (HBV) vaccination or I refuse such vaccination, I understand that due to my exposure to potentially infectious material, I may be at risk of acquiring HBV. I understand that by not obtaining this vaccine, I continue to be at an increased risk of acquiring HBV, a serious disease.

3. **Pregnancy and Breastfeeding Consent for Treatment**
   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 if I become pregnant during treatment including miscarriage 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 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.

4. **Employee Incident**
   In case of an employee needle stick injury or exposure to blood/bodily fluids, you consent to have your labs drawn by our clinical staff which would include, but not be limited to Hepatitis B, Hepatitis C and HIV.

5. **Assignment of Benefits**
   I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to Big Sky Managed Care for services provided to me. I understand benefits may be payable to me directly if I do not provide this authorization.

6. **Personal Valuables**
   I understand Big Sky Managed Care does not accept responsibility for any lost, stolen, or damaged personal items while I am at BSMC.

Patient Name: _____ Patient Date of Birth: _____
(Print)

X_____ _____
Patient or Legal Representative Signature Today's Date

If Signed by Legal Representative, Relationship to Patient (e.g. parent, spouse, etc.):

_____
Print Name and Provide Relationship

Appointment Cancellation Policy

We understand unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance.

Our nurses and pharmacists want to be available for your needs and all the needs of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

There will be a $50 fee assessed for all no-shows or cancellations made within 48 hours of your scheduled appointment. "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation.

By signing below, you acknowledge you have received this notice and understand this policy.

_____ _____

Patient Signature Date

_____

Patient Name (Print)

Authorization for Release of Protected Health Information
HIPAA Permission Note

I, _____, understand as part my health care, Big Sky Managed Care originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health care professionals who contribute to my care
- A means by which a third-party payer can verify services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand I have the right to request a Notice of Privacy (Information) Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- The right to review the notice prior to signing this Authorization
- The right to object to the use of my health information
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand Big Sky Managed Care is not required to agree to the restrictions I request and I understand I may revoke this authorization in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand refusing to sign this authorization or revoking this authorization allows the organization to refuse treatment to me as permitted by law. I further understand that Big Sky Managed Care reserves the right to change their notice and practices and prior to implementation will send a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I agree to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I fully understand and accept / decline the terms of this authorization.

Date: _____ Patient's Name Printed: _____

Signature of Patient: _____

Medical Information Release Form/HIPAA Phone Consent

Today's Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of all information including, but not limited to the diagnosis, records, examination and treatments rendered to me and claims information.

This information may be released to:
{ } Spouse (Print Name) _____

{ } Child(ren) (Print Name(s) _____

{ } Other (Print Name) _____

{ } I do not authorize information be released to anyone. (Initial & Date) _____

Phone Communications and Messages (Email/Text)

By supplying my home phone number, mobile phone number, email address and other personal contact information, I authorize Big Sky Managed Care (BSMC) to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, balances due, or any other healthcare related function. I also authorize BMSC to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple message per day, when necessary. I consent to allowing detailed messages being left by text, on my voice mail, answering system or with another individual, if I am unavailable at the number provided by me.

Please call:
{ } my home _____ { } my work _____ { } my cell _____

If unable to reach me:
You may leave a detailed message with protected health information. **YES** or **NO** Initial & Date _____

The best time to reach me is _____ between the hours of _____.

Email Address: _____

Signed: _____ Date: _____/_____/_____