Acknowledgement of Receipt *(Return via mail, email or fax)*

Name_____DOB: _____ Phone: _____

Address: _____

Please confirm that you received the UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy Welcome Packet by signing and sending back to us the following.

- Patient Acknowledgement & Assignment of Benefits
- HIPAA Rights of Access
- Credit Card Authorization

Completed forms may be mailed to:

UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
500 Remington Blvd,
Bolingbrook, IL 60440

FAX: 1-630-856-3992 | Email: GLR.SPS@adventhealth.com

With my signature below, I hereby acknowledge receipt of the above-mentioned forms.

_____ _____

Patient Signature Date

Assignment of Benefits

I hereby authorize UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment to UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy otherwise payable for me for all claims for such services provided or submitted prior to, or after, the date provided on this form. I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization in no way releases me from said responsibility and imposes no obligation on UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy to collect money on my behalf.

I have read, understand and agree to the Assignment of Benefits.

_____ _____

Patient Signature Date

_____

Patient Name

_____

Patient Address