



PATIENT WELCOME PACKET

Nursing Infusion Centers of America, **APC**

4254 Green River Road, Corona Ca. 92878

Phone: 866-936-0550

Fax: 866-936-5079

www.nica.us.com

Referrals: Referrals@nica.us.com

General Inquiries: Info@nica.us.com

Hours of Operation

Monday-Friday 9am-6pm **By Appointment Only**

Saturday-Sunday: **By Appointment Only**

*****After Hours: To reach an on-call staff member during non-business hours, please call 866-936-0550.**

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PATIENT WELCOME LETTER

Dear Patient

Welcome!

Thank you for choosing Nursing Infusion Centers of America, APC (NICA) for your infusion care needs. NICA is one of the only freestanding infusion centers offering a diverse set of infusion services in Corona, California. NICA is located near the following counties: Riverside County, Orange County, San Bernardino County, & Los Angeles. All is welcomed.

This Patient Welcome Guide is designed to assist you in preparing for your infusion visit while informing you of the services we offer. Our desire is for your visit to be smooth and as comfortable as possible.

NICA offers outpatient infusion services in a comfortable, welcoming setting. Instead of receiving IV medications in a hospital or at home where privacy may be limited, you can expect to receive services in our private, safe, & fully equipped infusion suites.

During your visit at NICA you will receive the highest quality and most comprehensive infusion care possible. NICA provides therapeutic intravenous injections by skilled nurses who are compassionate and specialize in administering infusion therapy. Our nurses are licensed Registered Nurses who are solely dedicated to patients' well-being.

If you have any questions after reading the enclosed information, please contact us immediately @ 866-936-0550. We look forward to serving you!

Sincerely,

Nursing Infusion Centers of America, APC Team

ABOUT US

HOURS OF OPERATION

Monday – Friday: 9am-6pm/ **By Appointment Only**

Saturday – Sunday: **By Appointment Only**

***After Hours: **To reach an on-call staff member during non-business hours, please call 866-936-0550.**
IF YOU THINK YOU HAVE A MEDICAL EMERGENCY CALL 9-1-1

MISSION

As a highly regarded healthcare partner to specialty pharmacies, physicians and patients, the Nursing Infusion Centers of America is committed to providing the ultimate standard of infusion care to improve patient health one infusion at a time.

VISION

The Nursing Infusion Centers of America vision is to revolutionize the infusion therapy delivery model while being recognized as America's infusion center of excellence.

PREPARING FOR YOUR APPOINTMENT

NEW REFERRALS

NICA is currently an alternate site for therapy. We will receive the initial referral from your Physician or Specialty Pharmacy provider. Once we receive your referral, we will contact you immediately to schedule your appointment based on your preference and availability.

SCHEDULING/RESCHEDULING/CANCELLING APPOINTMENTS

Please contact NICA by phone to schedule your appointment. You can expect to receive a reminder 24 hours prior your appointment.

If you need to reschedule or cancel your appointment, please call us as soon as possible or at least 24 hours in advance by calling 866-936-0550 and speaking with our staff.

YOUR APPOINTMENT TIME

Please arrive to your appointment at least 15-20 minutes before your scheduled appointments to allow time for parking and any paperwork requirements.

SERVICES

Nursing Infusion Centers of America provides therapeutic (NICA), intravenous infusions and injections on an outpatient basis. We are a community service provider for patients who need to start, continue, or complete intravenous therapy. Whether you are being released from hospitals, rehabilitation centers or skilled nursing facilities or simply prefer not to receive treatment at home, NICA is a preferred alternate site for infusion therapy.

For prescribed medications, we accept referrals from physicians and pharmacy partners.

NICA ADVANTAGES

- Flexible patient scheduling, with evening and weekend appointments available
- Quick turnaround for referrals
- First dosing capabilities and protocols Verification of insurance authorizations

NICA THERAPIES FOR ADMINISTRATION:

- Antibiotics
- Antifungals
- Hydration
- Parenteral nutrition
- Biologics
- Immune Globulins
- Hemophilia factor products
- Enzyme Replacement Therapies

ADDITIONAL SERVICES

- Wellness Vitamin and Hydration Services
- Catheter Care & Maintenance & De-clotting of PICC Lines
- Private Duty Services

EMERGENCY

In the **event of an emergency** or post infusion reaction, **please call 9-1-1** or your prescribing physician.

SIGNS & SYMPTOMS REPORTING (ONSITE):

- Swelling, redness, pain, or discomfort at insertion site of IV device
- Fever, chills, rash, shortness of breath
- Nausea, vomiting, dizziness
- If your PICC, Port, or IV dressing feels loose or unsecured.

AUTHORIZATIONS AND PAYMENTS

PRE-SCHEDULED VISITS

Patients referred by Physicians and/or Specialty Pharmacies to NICA will obtain authorization prior to your scheduled appointment and any co-payments will be collected prior to receiving care at NICA. No co-payments will be due at time of visit.

PRIVATE DUTY & HEALTH & WELLNESS PATIENTS

Accepted methods of payment:

Checks or Credit Cards.

Payments must be received prior to receiving service.

MEDICATION STORAGE/SUPPLIES & MANAGEMENT

ALTERNATE SITE FOR THERAPY

If you are receiving infusion services at NICA, it is important for you to bring your medications and supplies with you to your scheduled visit if your specialty pharmacy does not deliver your supplies and equipment to NICA directly.

While the medication is in your possession, it is important for you to store and maintain your medications according to the pharmacy's instructions. If you have any questions regarding the proper storage and handling of medications, please call your pharmacy for further instruction.

If your pharmacy decides to deliver your medications to NICA directly, someone will contact you on the day it arrives to let you know your medication has arrived.

INFUSION SUITES & AMENITIES

VIP TREATMENT

Because of our commitment to excellence we treat all patients like VIPs because they are. There is no waiting in a crowded waiting room. All infusion treatment experiences are by appointment only.

POSITIVE INFUSION EXPERIENCE

Patients –both pediatric and adults--can expect more than a routine infusion, but a complete infusion therapy experience provided by team of professionals who genuinely care about their well-being. The private, personal, and tailored experience creates a level of comfort and leads to positive outcomes.

COMFORT AND CONVENIENCE

NICA is designed to be a patient's infusion home away from home. Kick up your feet on relaxing recliners, surf the internet using our free high-speed Wi-Fi, curl up with a warm blanket and enjoy snacks and refreshments. When treatment is complete, return to work, home or social activities as usual.

NICA PRIVATE SUITE FEATURES

- Private Suites suited to accommodate patient and 1 guest
- Comfortable seating and recliners
- HEPA air filters
- High speed wi-fi
- Light snacks and beverages (Please feel free to bring your lunch or snack if you choose)
- Smart TV for your entertainment

COVID-19 CONSIDERATIONS

- Any persons entering the facility is required undergo temperature check.
- Infusion Suites will be restricted to patients only unless patient requires assistance.
- Any persons within the common areas of facility will be required to maintain social distancing at least 6 feet apart.
- NICA requires patients entering the facility to wear a mask during visit.
- Patients will receive a telephonic "Covid-19 Exposure Screening" 24 hours in advance and immediately prior to visit.
- Infusion suites and equipment will be cleaned and disinfected prior to and after patient visit.
- Infusion Nurses will always wear appropriate PPE (masks, gown, gloves, face & protection).
- If possible, NICA is asking for patients to call at time of arrival to facilitate being escorted directly into your suite.

If you have a fever, not feeling well, or believe you have been exposed to anyone who may be sick, please call and reschedule your appointment until you are deemed well by your health care provider.

PARKING CONSIDERATIONS

Parking is available in front of our facility or anywhere in the Sierra Del Oro Business Park that is not designated by or for other organizations.

REQUIRED FORMS FOR YOUR REVIEW & SIGNATURE

Immediately following this Patient Welcome Guide, you will find forms for you to review, sign, and return and/or retain for your records. Someone from our team will review these forms with you at the time of your visit. Once you have reviewed, please return designated forms to the receptionist or your nurse at the time of your visit.

- PATIENT BILL OF RIGHTS AND RESPONSIBILITIES
- PATIENT AUTHORIZATION AND PLAN OF SERVICE
- ADVANCE HEALTH CARE DIRECTIVE FORM
- PATIENT SATISFACTION SURVEY
- GRIEVANCE FORM

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We believe that all patients receiving services from Nursing Infusion Centers of America, APC should be informed of their rights. Therefore, you are entitled to:

- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of service
- Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the patient will be responsible. Medicare beneficiaries will be informed if assignment is not accepted.
- Receive information about the scope of services that the organization will provide and specific limitations on those services
- Participate in the development and periodic revision of the plan of service
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Be informed of patient rights under state law to formulate an Advanced Directive, if applicable
- Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality
- Be able to identify visiting personnel members through proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property
- Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
- Confidentiality and privacy of all information contained in the patient record and of Protected Health Information
- Be advised on facility's policies and procedures regarding the disclosure of clinical records
- Choose a health care provider, including choosing an attending physician, if applicable
- Receive appropriate care without discrimination in accordance with physician orders, if applicable
- Be informed of any financial benefits when referred to an organization
- Be fully informed of one's responsibilities

PATIENT RESPONSIBILITIES

- Patient submits forms that are necessary to receive services.
- Patient provides accurate medical and contact information and any changes.
- Patient notifies the treating provider of participation in the services provided by the facility.
- Patient notifies the facility of any concerns about the care or services provided.
- Patient maintains any equipment provided

When the patient is unable to make medical or other decisions, the family should be consulted for direction.

All staff members will understand and be able to discuss the Patient Bill of Rights and Responsibilities with the patient and caregiver(s). Each staff member will receive training during orientation and attend an annual in-service education class on the Patient Bill of Rights and Responsibilities.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

It is our duty to maintain the privacy and confidentiality of your protected health information (PHI). We will create records regarding you and the treatment and service we provide to you. We are required by law to maintain the privacy of your PHI, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the facility.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from our Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means providing services as ordered by your physician. Treatment also includes coordination and consultations with other health care providers relating to your care and referrals for health care from one health care provider to another. We may also disclose PHI to outside entities performing other services related to your treatment such as hospital, diagnostic laboratories, home health or hospice agencies, etc.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, prior approval, determinations of eligibility and coverage and other utilization review activities. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

Health care operations means the support functions of the facility, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. We may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.
- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- To disclose to your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.

We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

We will use or disclose PHI about you when required to do so by applicable law.

In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the facility as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:
 - to prevent or control disease, injury or disability;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; or
- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.

You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.

You have the right to inspect and copy the PHI contained in our facility records, except:

- for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);
- for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
- for PHI involving laboratory tests when your access is restricted by law;
- if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;
- if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
- for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
- for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You have the right to request an amendment to your PHI but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- is not part of your medical or billing records or other records used to make decisions about you;
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at our facility, along with a description of the reason for your request.

You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

- (i) to carry out treatment, payment and health care operations as provided above;
- (ii) incidental to a use or disclosure otherwise permitted or required by applicable law;
- (iii) pursuant to your written authorization;
 - to persons involved in your care or for other notification purposes as provided by law;
 - for national security or intelligence purposes as provided by law;
 - to correctional institutions or law enforcement officials as provided by law;
 - as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our facility. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the facility's Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington DC, 20201.

EMERGENCY PLANNING

This pamphlet has been provided by Nursing Infusion Centers of America, APC to help you plan your actions in case there is a natural disaster where you live. Many areas of the United States are prone to natural disasters like hurricanes, tornadoes, floods, and earthquakes.

Every patient receiving care or services in the home should think about what they would do in the event of an emergency. Our goal is to help you plan so that we can try to provide you with the best, most consistent service we can during the emergency.

Know What to Expect

- If you have recently moved to this area, take the time to find out what types of natural emergencies have occurred in the past, and what types might be expected.
- Find out what, if any, time of year these emergencies are more prevalent.
- Find out when you should evacuate, and when you shouldn't.
- Your local Red Cross, local law enforcement agencies, local news and radio stations usually provide excellent information and tips for planning.

Know Where to Go

One of the most important pieces of information you should know is the location of the closest emergency shelter.

These shelters are opened to the public during voluntary and mandatory evaluation times. They are usually the safest place for you to go, other than a friend or relative's home in an unaffected area.

Know What to Take with You

- If you are going to a shelter, there will be restrictions on what items you can bring with you. Not all shelters have adequate storage facilities for medications that need refrigeration.

- We recommend that you call ahead and find out which shelter in your area will let you bring your medications and medical supplies, in addition, let them know if you will be using medical equipment that requires an electrical outlet.
- During our planning for a natural emergency, we will contact you and deliver, if possible, at least one week's worth of medication and supplies. Bring all your services with you to the shelter.

Reaching Us if There Are No Phones

- How do you reach us during a natural emergency if the phone lines don't work? How would you contact us? If there is warning of the emergency, such as a hurricane watch, we will make every attempt to contact you and provide you with the number of our cellular phone. (Cellular phones frequently work even when the regular land phone lines do not.)
- If you have no way to call our cellular phone, you can try to reach us by having someone you know call us from his or her cellular phone. (Many times cellular phone companies set up communication centers during natural disasters. If one is set up in your area, you can ask them to contact us.)
- If the emergency was unforeseen, we will try to locate you by visiting your home, or by contacting your home nursing agency. If travel is restricted due to damage from the emergency, we will try to contact you through local law enforcement agencies.

An Ounce of Prevention...

We would much rather prepare you for an emergency ahead of time than wait until it has happened and then send you the supplies you need.

To do this, we need for you to give us as much information as possible before the emergency. We may ask you for the name and phone number of a close family member, or a close friend or neighbor. We may ask you where you will go if an emergency occurs. Will you go to a shelter, or a relative's home? If your doctor has instructed you to go to a hospital, which one is it?

Having the address of your evacuation site, if it is in another city, may allow us to service your therapy needs through another facility.

Helpful Tips

- Get a cooler and ice or freezer gel-packs to transport your medication.
- Get all of your medication information and teaching modules together and take them with you if you evacuate.
- Pack one week's worth of supplies in a plastic-lined box or waterproof tote bag or tote box. Make sure the seal is watertight.
- Make sure to put antibacterial soap and paper towels into your supply kit.
- If possible, get waterless hand disinfectant from Nursing Infusion Centers of America, APC or from a local store. It comes in very handy if you don't have running water.
- If you are going to a friend or relative's home during evacuation, leave their phone number and address with Nursing Infusion Centers of America, APC and your home nursing agency.
- When you return to your home, contact your home nursing agency and Nursing Infusion Centers of America, APC so we can visit and see what supplies you need.

For More information

There is much more to know about planning for and surviving during a natural emergency or disaster. Review the information from FEMA

http://www.fema.gov/areyouready/emergency_planning.shtm. The information includes:

- Get informed about hazards and emergencies that may affect you and your family.
- Develop an emergency plan.
- Collect and assemble disaster supplies kit, which should include:
 - Three-day supply of non-perishable food.
 - Three-day supply of water - one gallon of water per person, per day.
 - Portable, battery-powered radio or television and extra batteries.
 - Flashlight and extra batteries.
 - First aid kit and manual.
 - Sanitation and hygiene items (moist towelettes and toilet paper).
 - Matches and waterproof container.
 - Whistle.
 - Extra clothing.
 - Kitchen accessories and cooking utensils, including a can opener.
 - Photocopies of credit and identification cards.
 - Cash and coins.
 - Special needs items, such as prescription medications, eye glasses, contact lens solutions, and hearing aid batteries.
 - Items for infants, such as formula, diapers, bottles, and pacifiers.
 - Other items to meet your unique family needs.
- Learn where to seek shelter from all types of hazards.
- Identify the community warning systems and evacuation routes.
- Include in your plan required information from community and school plans.
- Learn what to do for specific hazards. - Practice and maintain your plan.

An Important Reminder!!

*During any emergency situation, if you are unable to contact our facility and you are in need of your prescribed medication, equipment or supplies, **you must go to the nearest emergency room or other treatment facility for treatment.***

HOME SAFETY

At Nursing Infusion Centers of America, APC, we want to make sure that your home medical treatment is done conveniently and safely. Many of our patients are limited in strength, or unsteady on their feet. Some are wheelchair - or bed-bound. These pages are written to give our patients some easy and helpful tips on how to make the home safe for home care.

Fire Safety and Prevention

- Smoke detectors should be installed in your home. Make sure you check the batteries at least once a year.
- If appropriate, you may consider carbon monoxide detectors as well. Ask your local fire department if you should have one in your home.
- Have a fire extinguisher in your home, and have it tested regularly to make sure it is still charged and in working order.
- Have a plan for escape in the event of a fire. Discuss this plan with your family.
- If you use oxygen in your home, make sure you understand the hazards of smoking near oxygen. Review the precautions. If you aren't sure, ask your oxygen provider what they are.
- If you are using electrical medical equipment, make sure to review the instruction sheets for that equipment. Read the section on electrical safety.

Electrical Safety

- Make sure that all medical equipment is plugged into a properly grounded electrical outlet.
- If you have to use a three-prong adapter, make sure it is properly installed by attaching the ground wire to the plug outlet screw.
- Use only good quality outlet "extenders" or "power strips" with internal Circuit breakers. Don't use cheap extension cords.

Safety in the Bathroom

- Because of the smooth surfaces, the bathroom can be a very dangerous place, especially for persons who are unsteady.
- Use non-slip rugs on the floor to prevent slipping.
- Install a grab-bar on the shower wall, and non-slip footing strips inside the tub or shower.
- Ask your medical equipment provider about a shower bench you can sit on in the shower.
- If you have difficulty sitting and getting up, ask about a raised toilet seat with arm supports to make it easier to get on and off the commode.
- If you have problems sensing hot and cold, you should consider lowering the temperature setting of your water heater so you don't accidentally scald yourself without realizing it.

Safety in the Bedroom

- It's important to arrange a safe, well-planned and comfortable bedroom since a lot of your recuperation and home therapy may occur there.
- Ask your home medical provider about a hospital bed. These beds raise and lower so you can sit up, recline, and adjust your knees. A variety of tables and supports are also available so you can eat, exercise, and read in bed.
- Bed rails may be a good idea, especially if you have a tendency to roll in bed at night.
- If you have difficulty walking, inquire about a bedside commode so you don't have to walk to the bathroom to use the toilet.
- Make sure you can easily reach the light switches, and other important things you might need through the day or night.
- Install night-lights to help you find your way in the dark at night.
- If you are using an IV pole for your IV or enteral therapy, make sure that all furniture, loose carpets, and electrical cords are out of the way so you do not trip and fall while walking with the pole.

Safety in the Kitchen

- Your kitchen should be organized so you can easily reach and use the common items, especially during your recuperation while you are still a bit weak:
- Have a friend or health care worker remove all common small appliances and utensils from cabinets, and place them on your counters where you can easily use them.
- Have a chair brought into the kitchen to the counter work area if you have difficulty standing.
- Make sure you are careful lifting pots and pans. Not only might they be hot, but they can be heavy as well. Use padded mitts to firmly grasp pans and pots on both sides.
- Ask your kitchen or hardware store about utensils for manually impaired or arthritic persons, including:
 - Basic electric can openers
 - Bottle and jar openers
 - Large-handled utensils
- When working at your stove, be very careful that intravenous, tube feeding tubing, or oxygen tubing do not hang over the heat. They can be flammable.

Getting Around Safely

- If you are now using assistive devices for ambulating (walking), here are some key points:
- Install permanent or temporary guardrails on stairs to give you additional support if you are using a cane or are unsteady.
- If you are using a walker, make sure that furniture and walkways are arranged to give you enough room.
- If you are using a walker or wheelchair, you may need a ramp for getting into or out of the house. Ramps can be purchased ready-made, or may be constructed for you. Talk to your home medical equipment provider about available options.

If you have any questions about safety that aren't in this booklet, please call us and we will be happy to give you recommendations for your individual needs.

INFECTION CONTROL

The patient/caregiver should observe all healthcare workers they meet and encourage and remind healthcare workers to wash their hands prior to providing care.

Items that touch only intact skin (e.g., blood pressure cuff, stethoscopes, thermometers, and other medical accessories) rarely, if ever, transmit disease. These items will be cleaned with alcohol after each use. Should any piece of item become contaminated with blood or other potentially infectious material, the item should be cleaned with a chemical germicide.

All excretions, secretions, blood, and drainage should be discarded in the toilet.

To minimize contamination during use, products must be handled in a manner that will protect them from contamination. These procedures include the following:

- Wash hands, making sure to use good hand washing technique.
- Unpack and handle products in a manner consistent with preservation of optimal cleanliness.
- Properly store all products

MAKING DECISIONS ABOUT YOUR HEALTH

Advance Directives are forms that say, in advance, what kind of treatment you want or don't want under serious medical conditions. Some conditions, if severe, may make you unable to tell the doctor how you want to be treated at that time. Your Advance Directives will help the doctor to provide the care you would wish to have.

Most hospitals and home health organizations are required to provide you with information on Advance Directives. Many are required to ask you if you already have Advance Directives prepared.

This pamphlet has been designed to give you information and may help you with important decisions. Laws regarding Advance Directives vary from state to state. We recommend that you consult with your family, close friends, your physician, and perhaps even a social worker or lawyer regarding your individual needs and what may benefit you the most.

What Kinds Of Advance Directives Are There?

There are two basic types of Advance Directives available. One is called a Living Will. The other is called a Durable Power of Attorney.

A Living Will gives information on the kind of medical care you want (or do not want) become terminally ill and unable to make your own decision.

It is called a "Living" Will because it takes effect while you are living.

Many states have specific forms that must be used for a Living Will to be considered legally binding. These forms may be available from a social services office, law office, or possibly a library.

In some states, you are allowed to simply write a letter describing what treatments you want or don't want.

In all cases, your Living Will must be signed, witnessed, and dated. Some states require verification.

A Durable Power of Attorney is a legal agreement that names another person (frequently a spouse, family member, or close friend) as an *agent* or *proxy*. This person would then be make medical decisions for you if you should become unable to make them for yourself. A Durable Power of Attorney can also include instructions regarding specific treatments that want or do not want in the event of serious illness.

What Type of Advance Directive is Best for Me?

- This is not a simple question to answer. Each individual's situation and preferences are unique.
- For many persons, the answer depends on their specific situation, or personal desires for their health care.
- Sometimes the answer depends on the state in which you live. In some states, it is better to have one versus the other.
- Many times you can have both, either as separate forms or as a single combined form.

What Do I Do If I Want An Advance Directive?

- First, consult with your physician's office or home care agency about where to get information specific for your state.
- Once you have discussed the options available, consult with any family members or friends who may be involved in your medical care. This is extremely important if you have chosen a friend or family member as your "agent" in the Durable Power of Attorney.
- Be sure to follow all requirements in your state for your signature, witness signature, notarization (if required), and filing.
- You should provide copies of your Advance Directive(s) to people you trust, such as close family members, friends and/or caregiver(s). The original document should be filed in a secure location known to those to whom you give copies.
- Keep another copy in a secure location; if you have a lawyer, he or she will keep a copy as well.

How Does My Health Care Team Know I Have an Advance Directive?

You must tell them. Many organizations and hospitals are required to ask you if you have one. Even so, it is a good idea to tell your physicians and nurses that you have an Advance Directive, and where the document can be found.

Many patients keep a small card in their wallet that states the type of Advance Directive they have, where a copy of the document(s) is located, and a contact person, such as your Durable Power of Attorney “agent,” and how to contact them.

What If I Change My Mind?

You can change your mind about any part of your Advance Directive, or even about having an Advance Directive, at any time.

If you would like to cancel or make changes to the document(s), it is very important that you follow the same signature, dating, and witness procedure as the first time, and that you make sure all original versions are deleted or discarded, and that all health care providers, your caregiver(s), your family and friends have a revised copy.

What If I Don't Want An Advance Directive?

You are not required by law to have one. Many home care companies are required to provide you with this basic information, but what you choose to do with it is entirely up to you.

For More Information...

This pamphlet has been designed to provide you with basic information. It is not a substitute for consultation with an experienced lawyer or knowledgeable social worker. These persons, or your home care agency, can best answer more detailed questions, and help guide you towards the best Advance Directive for you.

GRIEVANCE AND COMPLAINTS EXPLANATION

You may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 866-936-0550 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to 4254 Green River Road, Corona Ca. 92878. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this facility by calling Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at 919-785-1214 and/or the California Board of Registered Nursing at <https://www.rn.ca.gov/enforcement/complaint.shtml>.

Form Revised: 10/1/2020

Nursing Infusion Centers of America, APC

PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name: _____ ID _____

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to Nursing Infusion Centers of America, APC for services that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named facility, any and all information which will assist in processing my claims for services that I am receiving from the above named facility even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named facility any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for services that I have received, rather than directly to the above named facility, I agree to endorse those checks and send them immediately to the above named facility.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Nursing Infusion Centers of America, APC financial hardship program.

_____**(Initials)** I acknowledge that I have been advised of my financial responsibility to Nursing Infusion Centers of America, APC.

I hereby agree that Nursing Infusion Centers of America, APC or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the services / products ordered. I have received a copy of a patient handout that contains: Patient Bill Of Rights and Responsibilities, HIPAA Privacy Notice, Emergency Planning, Home Safety, Infection Control, Making Decisions about Your Health Care, Grievance / Complaint Reporting and Warranty Information.

I have received marketing material and information on the facility's scope of services. I have received instructions on how to follow up with Nursing Infusion Centers of America, APC

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 866-936-0550 to initiate complaint. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to 4254 Green River Road, Corona Ca. 92878. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this facility by calling Medicare at 1-800-MEDICARE, the Accreditation Commission for Health Care (ACHC) at 919-785-1214 and/or the California Board of Registered Nursing at <https://www.rn.ca.gov/enforcement/complaint.shtml>.

Identified needs/problems: The patient may be unfamiliar with use of the products provided. Expected outcomes: The patient will be provided the products to comply with the physician's prescription. The patient will use the products as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X _____ **DATE:** ____/____/____

PATIENT OR RESPONSIBLE PARTY

PRINT NAME: _____

IF BENEFICIARY IS UNABLE TO SIGN: _____

WITNESS SIGNATURE / RELATIONSHIP: _____

REASON PATIENT UNABLE TO SIGN: _____

Please return the Patient Authorization and Plan of Service Form to Nursing Infusion Centers of America, APC. Thank you for choosing Nursing Infusion Centers of America, APC.

ADVANCE HEALTH CARE DIRECTIVE EXPLANATION FORM

PAGE 1 of 7

Probate Code - PROB

DIVISION 4.7. HEALTH CARE DECISIONS [4600 - 4806] (Division 4.7 added by Stats. 1999, Ch. 658, Sec. 39.)

PART 2. UNIFORM HEALTH CARE DECISIONS ACT [4670 - 4743] (Part 2 added by Stats. 1999, Ch. 658, Sec. 39.)

CHAPTER 2. Advance Health Care Directive Forms [4700 - 4701] (Chapter 2 added by Stats. 1999, Ch. 658, Sec. 39.)

4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE (California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (e) Donate your organs, tissues, and parts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs, tissues, and parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

ADVANCE HEALTH CARE DIRECTIVE FORM

PART 1 POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

(address)

(city)

(state)

(ZIP Code)

(home phone)

(work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address)

(city)

(state)

(ZIP Code)

(home phone)

(work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address)

(city)

(state)

(ZIP Code)

(home phone)

(work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box , my agent's authority to make health care decisions for me takes effect immediately.

ADVANCE HEALTH CARE DIRECTIVE FORM

(1.4.) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

:

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

**PART 2
INSTRUCTIONS FOR HEALTH CARE**

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS, TISSUES, AND PARTS AT DEATH
(OPTIONAL)

(3.1) [] Upon my death, I give my organs, tissues, and parts (mark box to indicate yes).
By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

My donation is for the following purposes (strike any of the following you do not want):

- (a) Transplant
(b) Therapy
(c) Research
(d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (ZIP Code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (ZIP Code)

(phone)

ADVANCE HEALTH CARE DIRECTIVE FORM

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

(date) (sign your name)

(address) (print your name)

(city) (state)

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness

Second witness

(print name) (print name)

(address) (address)

(city) (state) (city) (state)

(signature of witness)

(signature of witness)

(date) (date)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

(signature of witness)

(signature of witness)

**PART 6
SPECIAL WITNESS REQUIREMENT**

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

(date)

(sign your name)

(address)

(print your name)

(city) (state)

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California,
County of

On _____ before me,

_____ (insert name and title of officer)

personally appeared

_____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person (s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature

(SEAL)

Nursing Infusion Centers of America, APC

PATIENT SATISFACTION FORM

Date: _____

Dear Patient,

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and mail it back to us. Thank you.

Were your medications (equipment and supplies, if applicable) administered on time by the Infusion Nurse at the facility?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were the medications (equipment and supplies, if applicable) administered accurately by the Infusion Nurse?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you or your caregiver educated about the side effects of your medications and what to report during the time of your infusion?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the facility staff courteous and helpful?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were your financial responsibilities explained to you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did you receive help when requested?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the services provided make a positive impact on the outcome of your care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you recommend our services to friends and family?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the services provided meet your needs and expectations?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you have a compliment about the infusion center are you ok sharing it anonymously on our NICA Website?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COMMENTS (OPTIONAL)

Signature (optional) _____

Form Revised: 10/1/2020

GRIEVANCE FORM

Date _____

Time _____

Complainant Name: _____

Patient/Client Name: _____

Relation to you: _____

Cell Phone Number: _____

Address, City, State: _____

Date Services Began: _____

Date Problem Occurred: _____

Complaint: Please use this form if you would like to submit a written concern.

Please provide a brief and factual summary of your issue(s) with any information you feel may assist in our investigation. Please include as many details as possible, including dates and times of events that relate to your complaint, as well as names of persons who have information about the complaint and the names of any persons with whom you have discussed the events relating to the complaint, and your best recollection of the dates and times of any of these discussions.

Have you contacted the provider/accredited organization directly regarding your complaint?

YES: _____ NO: _____

NICA strives to ensure the highest standards of Ambulatory Infusion Services in alignment with our Mission. If you have any concerns about your services received by NICA, please call 866-936-0550. Within five (5) business days of receiving the concern, we will notify you that the complaint has been received. Within 14 days, we will provide you with written notification of the results. In the event you are dissatisfied with the results or feel your complaint remains unresolved, you may file a complaint with our Accreditor, ACHC, via their website (www.achc.org) or via phone (855) 937-2242.

Thank you for your assistance in our continuing efforts to ensure quality infusion services at NICA.

Sincerely,

NICA Team