McKesson Patient Care Solutions

New Patient Packet Acknowledgment and Contact Authorization

New Patient Packet Acknowledgment

By my dated signature below, I acknowledge receipt of the McKesson Patient Care Solutions Inc. New Patient Packet which includes the following: Contact Information, Patient Freedom of Provider Statement, Medicare Supplier Standards, Return Policy, Warranty, Notice of Privacy Practices, MPCS Customer Rights and Responsibilities, Civil Rights Notices, Product Education and Be Red Cross Ready.

Print Name: _____

Date of Birth: _____ / _____ / _____

Primary Caregiver Name: _____ Relationship: _____ Phone Number: _____

Signature: _____ Date: _____ / _____ / _____

If you are the legal representative of the individual listed above, please check the basis for your authority:

❑ Power of Attorney (attach copy) ❑ Guardianship Order (attach copy)

❑ Parent of Minor ❑ Other (please specify _____

Legal Representative Name *(please print)* _____

Legal Representative Signature _____ Date: _____ / _____ / _____

Contact Authorization

You are receiving this authorization request because McKesson Patient Care Solutions Inc. (MPCS) uses prerecorded messages, text messaging[1],and electronic correspondence to remind our customers that it may be time for a supply reorder or to deliver other important messages. We would like your permission to use these types of messaging. You are not required to sign this agreement in order to continue to receive products from MPCS.

Please confirm your authorization for each of the following options by checking "yes," or "no." If you choose yes, please list the phone number and/or email address that you authorize MPCS to contact through its automated technology.

I understand that MPCS provides me with medically necessary products and may need to contact me regarding my order, reorder or to provide other necessary information regarding my products. I authorize MPCS to contact me via the communication options selected below.

I agree to be contacted by phone. ❑ Yes ❑ No

I agree to be contacted by text messaging. ❑ Yes ❑ No

I agree to be contacted by email. ❑ Yes ❑ No

Phone Number: _____ Indicate: ❑ Cell Number ❑ Land Line

Phone Number: _____ Indicate: ❑ Cell Number ❑ Land Line

Email Address: _____

Print Name: _____

Date of Birth: _____ / _____ / _____

Signature: _____ Date: _____ / _____ / _____

To acknowledge receipt and grant this permission, please complete, sign and return this form in the enclosed business reply envelope.

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[1] Standard text messaging rate may apply.