



**PA22 – PT CONTRACT
SAMPLE PATIENT CONTRACT FOR RECEIVING
TREATMENT for HEPATITIS C**

**Executive Office of Health & Human Services (EOHHS)
RI MEDICAID FEE FOR SERVICE (FFS)**

***THIS IS A SAMPLE PATIENT CONTRACT FOR RECEIVING TREATMENT WITH DAA MEDICATIONS,
OR YOU MAY CHOOSE TO USE YOUR OWN VERSION OF A PATIENT CONTRACT***

INSTRUCTIONS:

- ***PRESCRIBER REPRESENTATIVE TO REVIEW WITH PATIENT***
- ***PATIENT TO SIGN A PATIENT CONTRACT***
- ***PERSON ADMINISTERING CONTRACT TO SIGN***
- ***ADD CONTRACT TO PATIENT MEDICAL RECORD.***
- ***DO NOT SEND PATIENT CONTRACT THE PA REQUEST***

I, _____, understand and agree to the following;

(PRINTED PATIENT NAME)

1. It is essential that I take my medication every day, exactly as prescribed by my physician.
2. Missing doses of medication may lead to complete treatment failure and lack of a cure of my Hepatitis C infection. Failure to follow medication directions will result in my provider not renewing my medication.
3. Failure to complete all required office visits and/or laboratory testing will result in discontinuing my supply of prescription medication.
4. My medication is being prescribed for a limited period of time based on best practice guidelines for treatment of my Hepatitis C infection.
5. The goal of my treatment is to cure my Hepatitis C infection. I understand that if successful I will not be safe from re-infection and additional disease complications.
6. Successful treatment of my Hepatitis C will not reverse already present liver disease or other illness unrelated to Hepatitis C.
7. If applicable, I will continue to participate in my alcohol or intravenous therapy and monitoring programs while receiving Hepatitis C treatment and recognize the risk of recurring Hepatitis C and complications with return to alcohol or intravenous drug abuse.
8. I have received education about Hepatitis C treatments, complications and re-infection and have had all of my disease related questions answered to my satisfaction.

PATIENT SIGNATURE _____ **DATE:** ____ / ____ / _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THAT THE CONTRACT HAS BEEN REVIEWED WITH THE PATIENT, IT IS VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

FOR OFFICE USE:

PRINTED NAME OF PERSON ADMINISTERING CONTRACT: _____

SIGNATURE OF PERSON ADMINISTERING CONTRACT: _____

DATE: ____ / ____ / _____