

## Language Assistance Services

We<sup>1</sup> provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in large print. To get help, please call **877-342-9352**, TTY 711. We are available Monday through Friday, 8 a.m. to 5:30 p.m. CST.

**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

**XIN LƯU Ý:** Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

**PAALALA:** Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

**ВНИМАНИЕ:** бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا نكثت خدمات الترجمة العربية (**Arabic**)، فإن خدمات السماعة الـغوية لـمجانبة تـمـا حـة كـل. لـا رـجـاء صـتـلـال رـ لـع رـقـم لـا هـا فـت لـا مـجـا رـ بـن الـد و جـوم ر لـع مـعـر ف ي و ضـعـلـا.

**ATANSYON:** Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

**ATTENTION :** Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

**UWAGA:** Jeżeli mówisz po **polsku (Polish)**, udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

**ATENÇÃO:** Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

**ATTENZIONE:** in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

**ACHTUNG:** Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(**Japanese**)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

جوتہ: رگہا بزنا مشا ا **فرسی (israF)** است، دخدمات امداد بزانی به روط گ یارنارد ی تخار مشا یم ب شاد. لطف با شما هم فو لمتن گ یارای بن کن یورک اثر انشسای می مشا دیق ه ش متاس دیر گب.

ध्यान दें: यदद आप ह **दी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नन:शुल्क उपलब्ध है। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

<sup>1</sup> This Notice of Privacy Practices applies to the following entities: Home Care I.V. of Bend, LLC, Infu Source LLC, Access I.V., LLC, Sirona Infusion, LLC, ARC Infusion, LLC, Summit Home Infusion, LLC, Advanced Care and all its directly owned subsidiaries, Sequinox LLC, Guardain Health Systems LP, Ambient Healthcare of South Florida Inc., Ambient Healthcare of West Florida, Inc., Ambient Healthcare of Central Florida, Inc., Ambient Healthcare of Northeast Florida, Inc., Ambient Nursing Services, Inc., Ambient Healthcare of Georgia, Inc., Nutritional/Parenteral Home Care, Inc., Nutritional/Parenteral Home Care of Huntsville, Inc., Pronetics Health Care Group, Inc., Trinity Infusion, Inc., AxelaCare Healthcare, LLC, Home Infusion with Heart, LLC

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍ ៖ បបរើសវិសមុខ គនីយាយ **ភាសាខ្មែរ (Khmer)** បសវាជន្ត យភាសាចោយគគកិកថុលវៃ គីមានសំរាប់អុន ក។ សូ មុន្តរស័ព្ទទេវាបេឌគគកិកថុលវៃ ដែលមានចៅបេវើអុគដស្ត្រា ណប័ណ្ណ របសអុន ក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqoqdí ninaaltsoos nítł'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

This Notice of Privacy Practices applies to the following entities: Home Care I.V. of Bend, LLC, Infu Source LLC, Access I.V., LLC, Sirona Infusion, LLC, ARC Infusion, LLC, Summit Home Infusion, LLC, Advanced Care and all its directly owned subsidiaries, Sequinox LLC, Guardain Health Systems LP, Ambient Healthcare of South Florida Inc., Ambient Healthcare of West Florida, Inc. , Ambient Healthcare of Central Florida, Inc., Ambient Healthcare of Northeast Florida, Inc., Ambient Nursing Services, Inc., Ambient Healthcare of Georgia, Inc., Nutritional/Parenteral Home Care, Inc., Nutritional/Parenteral Home Care of Huntsville, Inc., Pronetics Health Care Group, Inc., Trinity Infusion, Inc., AxelaCare Healthcare , LLC, Home Infusion with Heart, LLC

## Notice of Non-Discrimination

We<sup>1</sup> do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

BriovaRx Infusion Services  
Civil Rights Coordinator  
15529 College Blvd  
Lenexa, KS 66219

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call **877-342-9352**, TTY 711. We are available Monday through Friday, 8 a.m. to 5:30 p.m. CST.

You can also file a complaint with the U.S. Dept. of Health and Human services.

**Online** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

<sup>1</sup>For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "We" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices. Please note that not all entities listed are covered by this Notice.

# Notice of Privacy Practices

## What You Should Know About Your Right to Privacy

Effective January 1, 2017

**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.**

BriovaRx Infusion Services is required by law to protect the privacy of your health information and to send you this notice. The notice explains how we may use information about you and when we<sup>1</sup> can give out or “disclose” that information to others. You have rights to your health information that are described in this notice. We are required by law to follow the terms of this notice.

We have the right to change our privacy practices and the terms of this notice at any time. You may obtain the most current notice by visiting the **Privacy** section of our website, [BriovaRxinfusion.com](http://BriovaRxinfusion.com), or by contacting us at 877-342-9352. We will mail a copy of the revised notice to you, if you make your request on or after the notice’s effective date. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

The terms “information” and “health information” in this notice include any information we have that reasonably can be used to identify you and that relates to your physical or mental health condition, the health care you receive or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

### How We Use or Disclose Information

**We must** use or disclose your health information to provide information to:

- You or someone who has the legal right to act for you (your personal representative), to administer your rights as described in this notice; and
- The Secretary of the U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected.

**We have the right to** use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment.** We may use or disclose health information to obtain payment for your health care services. For example, we may disclose your health information to your health insurance company to collect payment for your pharmacy services.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to treating physicians or others involved in your care, regarding possible drug interactions.

- **For Health Care Operations.** We may use or disclose health information as needed to operate and manage our business activities related to providing and managing your health care. For example, we might analyze your information to determine ways to improve our services.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs about health-related products and services, subject to the limits of the law.
- **For Reminders.** We may use or disclose health information to send you reminders about your care, such as prescription-refill reminders.

We may use or disclose your health information for the following purposes, under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure of information is in your best interest. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are permitted by law to receive such information, including social services or protective service agencies.
- **To Health Oversight Agencies** for activities permitted by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Health or Safety Threat** to you, another person, or the public. For example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services of the President and others.
- **For Workers' Compensation** as permitted by, or to the extent needed to comply with, state workers' compensation laws that govern job-related injuries or illness.
- **For Research Purposes** related to evaluating certain treatments or to prevent disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

- **For Organ Procurement Purposes.** We may use or disclose information to people and organizations who procure, bank or transplant organs, eyes or tissue, to help with organ donations and transplants.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution 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.
- **To Business Associates** that perform activities on our behalf or provide us with services if the information is necessary for such activities or services. Business associates are required, under contract and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as stated in our contract and permitted by law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that limit the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include the following types of information:
  1. HIV/AIDS;
  2. Mental health;
  3. Genetic tests;
  4. Alcohol and drug abuse;
  5. Sexually transmitted diseases and reproductive health information; and
  6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. See the "Federal and State Amendments" section.

Except for the allowed and required uses and disclosures described in this notice, we will use and disclose your health information only with written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization.

Once you authorize us to release your health information, we cannot guarantee that the recipient we gave the information to is obligated to protect and will not further disclose your information. You may take back or "revoke" your written authorization at any time in writing. This will not apply to uses and disclosures we have already acted upon based on your initial authorization. To find out how to take back your authorization, see our contact information in the section called "Exercising Your Rights."

**Your rights**, with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. You must make a written request to restrict the use or disclosure of your information. See instructions in the "Making a Written Request" section. **Please note that while we will try to honor your request, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
- **You have the right to request that we not send health information** to health plans in certain cases if the health information is about a health care item or service for which you or a person on your behalf has paid us in full. You must

make this request — either verbally or in writing — at the time you submit or call in your order. We will agree to all requests meeting the above criteria and submitted in a timely manner.

- **You have the right to ask to receive confidential communications** by asking us to send information by alternative means or at alternative locations — for example, to another address instead of your home address. You must make a written request to receive confidential communications or to cancel or change an earlier request. Please see the section called “Making a Written Request” for instructions. We will honor reasonable requests.
- **You have the right to ask to make changes** to certain health information we maintain about you, such as medical records and billing records, if you believe the health information about you is wrong or incomplete. You must make a written request to change your information and explain your reason(s) for the requested change(s). Please see the “Making a Written Request” section for instructions. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to see and obtain a copy** of certain of your health information maintained by us, such as your medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you name. In some cases, you also may receive a summary of this health information. You must make a written request to inspect and obtain a copy of your health information. Please see the section called “Making a Written Request” for instructions. In certain cases, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to receive a listing** of certain disclosures of your information made by us during the six years before your request. This list will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or people you authorized; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to keep track of. You must submit a written request for a list of disclosures. Please see the “Making a Written Request” section for instructions.
- **You have the right to request a paper copy of this notice at any time.** You may ask for a copy of this notice at any time by calling our customer service advocates at 877-342-9352. Even if you have agreed to receive this notice electronically, you can still request additional paper copies of this notice. You may also view and/or print a copy of this notice at our website, [BriovaRxinfusion.com](http://BriovaRxinfusion.com).

## Exercising Your Rights

**Making a Written Request.** You must submit a written request to exercise certain rights. For your convenience, we have created Individual Rights Request forms for you to use to ensure that we properly document and process your request. To obtain a form:

- Contact Customer Service at 877-342-9352 and have us mail a form to you.

Then, mail or fax your completed **Individual Rights Request** form to the Privacy Office. The contact information is in the “Questions About This Notice or to File a Complaint” section.

**Designating a Personal or Authorized Representative** so that BriovaRx Infusion Services may discuss and give out your health information to a third party named by you, you must send to us written material that names that person, such as:

- A legal document granting personal representation such as health care power of attorney, guardianship, or conservatorship. Or,

- A completed **Authorization** Form. To obtain a form:
  - Contact Customer Service at **877-342-9352** and have us mail a form to you.
  - Mail or fax completed forms to:  
BriovaRx Infusion Services  
Attn: Privacy Office  
15229 College Blvd  
Lenexa, KS 66219  
Fax: 1-866-889-2116

**Questions About this Notice or to File a Complaint.** If you have questions about this notice, please contact the Privacy Office. Also, if you believe your privacy rights have been violated, you may file a complaint with us. **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

- Contact us by mail, phone or fax:

BriovaRx Infusion Services  
Attn: Privacy Office  
17900 Von Karman Ave  
M/S: CA016-0102  
Irvine, CA 92614  
Phone: 1-877-598-3646  
Fax: 1-888-905-9490

## Notice of Privacy Practices: Federal and State Amendments

Revised: January 1, 2017

The first part of **this** Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health **information** under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purposes of the following charts are to:

1. Show the types of health information that apply to these more restrictive laws; and
2. Give you a **general** summary of when we can or cannot use and disclose your health information **without your consent.**

If your written consent is required **under** the more restrictive laws, the consent must meet the rules of the federal or state law.



## Summary of Federal Laws

### Alcohol and Drug Abuse Information

We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited situations, and/or disclose only (2) to specific recipients.

## Summary of State Laws

### General Health Information

We are allowed to disclose general health information only (1) under certain limited cases, and/or (2) to specific recipients.	CA, CO, DE, FL, GA, IN, MN, MT, NJ, NY, PR, RI, TN, WA
You may be able to limit certain electronic disclosures of health information.	NV
We are not allowed to use or disclose health information for certain purposes.	CA, FL, MT, NH, TN
We will not use and/or disclose information about certain public assistance programs except for certain purposes.	AL, CA, MO, MT, NV, NJ, SD, TX
We are allowed to disclose certain immunization records only (1) under certain limited conditions, and/or disclose only (2) to specific recipients.	FL, NV
We must limit access to records of minors under a protective court order.	IL
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
We are allowed to disclose your health information only for limited research purposes	WA

### Prescriptions

We are allowed to disclose certain prescription-related information only (1) under certain limited conditions, and/or (2) to specific recipients.	CT, FL, GA, ID, IN, KY, MI, NE, NV, OH, RI, SC, TN, WV
---	--

### Communicable Diseases

We are allowed to disclose communicable disease information only (1) under certain limited situations, and/or (2) to specific recipients.	AZ, IA, IN, MI, MT, NV, NM, OK
---	--------------------------------

### Sexually Transmitted Diseases and Reproductive Health

We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited conditions and/or (2) to specific recipients.	AZ, CA, FL, IN, MA, MI, NV, NJ, OK, WA, WV, WY
We are not allowed to identify certain abortion patients in legal proceedings	OK

### Alcohol and Drug Abuse

We are not allowed to disclose alcohol and drug abuse information without your written consent.	WV
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited conditions, and/or disclose only (2) to specific recipients.	CA, CT, FL, GA, IL, IN, IA, LA, MD, MA, MI, MS, NV, NC, OK, PA, TN, VA, WI

### Genetic Information

We are not allowed to disclose genetic information without your written consent.	KS, NH, NY
We are allowed to disclose genetic information only (1) under certain limited conditions and/or (2) to specific recipients.	AK, AZ, FL, IL, LA, ME, MA, MO, NH, NV, NJ, NM, OR, RI, TX, VT
Restrictions apply to (1) the use, and/or (2) the storing of genetic information	AK, DE, NM, OR

<b>HIV/AIDS</b>	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited conditions and/or (2) to specific recipients.	AZ, CA, CO, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MD, MA, MI, MO, MT, NE, NV, NH, NM, NY, NC, OH, OK, OR, PA, PR, RI, TX, WA, WV, WI, WY
Certain limits apply to oral disclosures of HIV/AIDS-related information.	CT, FL
<b>Mental Health</b>	
We are not allowed to disclose mental health information without your written consent.	PR, UT
We are allowed to disclose mental health information only (1) under certain limited conditions and/or (2) to specific recipients.	AK, AZ, CA, CT, DC, IA, IL, IN, ME, MD, MI, MS, NV, NH, NJ, NM, NC, OK, PA, SC, SD, TN, TX, UT, WA, WI
Certain limits apply to oral disclosures of mental health information.	CT
<b>Child or Adult Abuse</b>	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited conditions, and/or disclose only (2) to specific recipients.	IL, MD

# Acknowledgment of Receipt of BriovaRx Infusion Services Notice of Privacy Practices

By signing this document, I state that I have received a copy of the BriovaRx Infusion Services Notice of

Privacy Practices. Name (print): \_\_\_\_\_

Patient ID # (optional): \_\_\_\_\_

Patient Street Address: \_\_\_\_\_

Patient City, ST, ZIP: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Have You Remembered to:

- Keep the **Notice of Privacy Practices** brochure for your records?
- Sign and date this acknowledgment of receipt?

### **Mail in your acknowledgement of receipt:**

You can return this acknowledgment of receipt  
to the following address for our records:

BriovaRx Infusion Services

Attn: Privacy Office

15529 College Blvd

Lenexa, KS 66219

This Notice of Privacy Practices applies to the following entities: Home Care I.V. of Bend, LLC, Infu Source LLC, Access I.V., LLC, Sirona Infusion, LLC, ARC Infusion, LLC, Summit Home Infusion, LLC, Advanced Care and all its directly owned subsidiaries, Sequinox LLC, Guardain Health Systems LP, Ambient Healthcare of South Florida Inc., Ambient Healthcare of West Florida, Inc. , Ambient Healthcare of Central Florida, Inc., Ambient Healthcare of Northeast Florida, Inc., Ambient Nursing Services, Inc., Ambient Healthcare of Georgia, Inc., Nutritional/Parenteral Home Care, Inc., Nutritional/Parenteral Home Care of Huntsville, Inc., Pronetics Health Care Group, Inc., Trinity Infusion, Inc., AxelaCare Healthcare , LLC, Home Infusion with Heart, LLC