PHARMACY SERVICES AGREEMENT

St. James Long Term Care Pharmacy, LLC will supply prescriptions, provide medication administration records (MARs), free delivery service, consultations by pharmacists and associates and 24-hour "after hour service". We will bill your prescription insurance and charge you the standard copay amount, just like other retail or long term care pharmacy. If a medication is not on your insurance formulary, we will contact the prescriber to ask for an authorization or a medication change and discuss with you any new costs or options.

By completing this agreement, you:

- Authorize St. James Long Term Care Pharmacy, LLC to supply services and are responsible for all payments and copayments covered or not covered by your insurance.[1]
- Disclosed correct and accurate billing information and update any changes.
- Agree all delivered medications that were subsequently discontinued or modified by your physician or otherwise not used for any reason cannot be returned for credit.
- Allow St. James Long Term Care Pharmacy, LLC to contact the prescriber to ask for an authorization or medication change, if the medication is not on the insurance formulary.
- Waived your right to receive prescriptions in child resistant packaging with PASS packaging.
- Received the HIPPA notice and authorize St. James Long Term Care Pharmacy, LLC to obtain or disclose pertinent personal and medical information with other medical professionals according to HIPPA guidelines.

Patient Name: _____Facility_____

Patient DOB: _____/_____/_____Patient SSN: _____Medicare ID: _____

Primary Insurance Company Name: _____

ID: _____RX Group: _____RX Bin:_____PCN: _____

Policy Holder: _____Primary Insurance Company Phone #:_____

Secondary Insurance Company Name: _____

ID: _____RX Group: _____RX Bin:_____PCN: _____

Policy Holder: _____Insurance Company Phone #:_____

Please attach copies of the front and back of the
Patient's Insurance Cards and the Responsible Party's Driver's License.

Financially Responsible Party's Signature: _____Date: _____

Responsible Party Name: _____Relationship: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____Cell: _____ Email: _____

[1]Any discrepancies on the statement must be addressed within 30 days in order to attempt to electronically resubmit the claim again. All payments are due within 30 days and if the payment is not received, the finance charge will be added and computed at a period rate of 2.5% per month with a $5.00 fee. Detailed statements are sent out every month and reflects all costs paid and not covered by the insurance plan including any prescriptions and copays. Any charges remaining 90 days past due, a credit hold will be placed on the account and suspend medication delivery. PHI Release v2.0 10/31/2017

HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ **SSN:** _____

I. My Authorization

I authorize St James Long Term Care Pharmacy, LLC to use or disclose the following health information.

(Select One)

☐ **All of my health information including current medications and history profile**

☐ My health information relating to the following treatment or condition:

_____

☐ My health information covering the period of healthcare from (date) _____ to (date) _____

☐ Other: _____

The above party may disclose this health information to the appropriate third parties as required for business and patient care as stated in the NOTICE FOR PRIVACY POLICY and the policies stated herein.

(Optional) This authorization ends: On (date) _____

Or when the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
I understand that uses and disclosures already made based upon my original permission cannot be taken back retroactively. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age

☐ Patient is unable to sign because: _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order/POA ☐ Other: _____

NOTICE OF PRIVACY PRACTICES POLICY

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective date of this notice: 12/01/2014
- Cecilia Marasigan, Privacy Officer, cecilia@stjamesltcp.org
- We never market or sell personal information.

OMB Approval No. 0938-0975

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

Form CMS-10147 (Approved 09/30/2014)

Patient Name: _____**Facility/Room No**. :_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice Effective Date: 12/01/2015

I acknowledge that I have received your Notice of Privacy Practices with an effective date of December 1, 2015, containing a more complete description of the uses and disclosures of my health information and understand their commitment to protecting my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Date: _____

Signature: _____

Printed Name: _____

Authorized Representative Only:

I certify that I am the authorized representative of above-identified patient, and that I have received the Privacy Notice with an effective date of December 1, 2015 on behalf of this individual and that the above-named entity provided me with an opportunity to review this document and ask questions to assist me in understanding the patient's privacy rights. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting health information.

Date: _____

Signature of Representative: _____

Printed Name: _____

Relationship to Individual: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but unable to do so as documented below:

Date	Initials	Reason

A copy of this document must be provided to the person to whom the Privacy Notice was provided and a copy must be filed in the patient's record.