434 Hurricane Lane, Williston, VT 05495
802-655-3544 or 1-800-638-1675 Fax 802-655-0123
www.freedompharmacyvt.com

Dear New Customer:

Enclosed you will find five documents that need your immediate attention. We do require that you fill out these forms and return to the address above as soon as possible and before services can be started.

1. **Demographic Intake sheet**
   This sheet asks for your basic demographic and insurance information to get you set up in our system. Please complete as thoroughly as possible to avoid follow up questions. There is also an area to complete a Non-Safety Cap Request, this is required as the Medicine-On-Time packages are not child resistant.

2. **Medication List**
   Please list all the medications you take including any over the counter medications. If you take your medications at a certain time of the day please indicate that as well.

3. **Notice of Privacy Practices**
   Please take a minute to read our copy of our Notice of Privacy Practices. Afterwards, please sign the Acknowledgment to send back to us.

4. **Medical Release Form & Guarantee of Payment Form**
   We also need you to fill out a medical release if you wish for us to be able to discuss your healthcare and/or related finances with anyone other than yourself. The second part of this form is a guarantee to the pharmacy that, if you receive medications/products that are not covered by your insurance or you have insurance co-payments for medications that are covered; you or your guarantor (payee) will be responsible for the payments.

5. **Automatic Credit Card or ACH Payment Authorization Form**
   In order to join the Medicine-On-Time program, Freedom Rx will need to have automatic payment information on hand before services are started. Please fill out the form, sign, date and send back to us with the other forms. If you are unable to provide a credit card or savings/checking account for automatic payment but would still like to enroll in the Medicine-On-Time Program, please call us so that we can discuss other options.

   Thank you for taking the time to complete these forms.

   Sincerely,

   Freedom Pharmacy

The products and/or services provided to you by Freedom Pharmacy are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

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Name: ______________________ ☐ Male ☐ Female

Address: ______________________

Phone: __________ Cell: __________ DOB: __________

Email: __________ Previous Pharmacy: __________

Contact: __________ Phone: __________

Insurance: __________ SS#: __________

Primary Doctor: __________ Phone: __________

Other Doctor: __________ Phone: __________

Drug Allergies: ______________________

Chronic Conditions: ______________________

____

Need Medication Administration Record (MAR)? ☐ YES ☐ NO

Delivery Method: ☐ DELIVERY ☐ MAIL ☐ PICK UP

Requested Cycles: ☐ 7 DAY ($30/month) ☐ 14 DAY ($10/month) ☐ 28 DAY (NO FEE) ☐ VIALS (NO FEE)

Frames needed ($): ☐ YES ☐ NO

Requested Start Date: __________ Referred by: __________

Are PRN (as needed) medications ok in Vials? ☐ YES ☐ NO, please bubble pack

Federal law requires that your medication be dispensed in a container with a child resistant or safety cap. If you would like your prescriptions in Medicine-On-Time packaging and with an "Easy-Open" lid, please sign below:

I request that my prescriptions and all refills of my prescriptions be dispensed in "Easy-Open" or Non-child resistant containers.

Signature: ______________________ Date __________

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MEDICATION LIST for: ______________________ Patient's DOB: ____________

Address: ______________________________________

Please provide a complete medication list including but not limited to insulin, anti-coagulants, Over the Counter (OTC) items, incontinence supplies, inhalers, and controlled or narcotic medications (dispensing a narcotic medication requires an electronic or hand written prescription).

MEDICATION	DIRECTIONS	DIAGNOSIS

All orders are valid for 1 year unless otherwise noted and in accordance with Federal and State Pharmacy Law and will be dispensed according to your decision on what medication cup format is chosen (i.e. 7, 14 or 28 day supplies). Controlled III-V medications are limited to 6 months or 5 refills per Federal/State Law.

Physician Name: ______________________

Physician Signature: ______________________ Date ____________

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NOTICE OF PRIVACY PRACTICES

Our company is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the services we provide to you.

This Notice tells you about the ways in which Freedom Pharmacy (referred to as "we") may collect, use, and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you that can reasonably be used to serve you and that relates to you, or the payment for that care.

We are required by law to maintain the confidentiality of health information that identifies you; and to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. If you have questions about this notice, please contact our Privacy Officer for further information.

The terms of this notice apply to all records containing your health information that are created or retained by our organization. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records we have created or maintained in the past, and for any of your records we may create or maintain in the future. Our organization will post a copy of our current notice in our office in a prominent location, and you may request a copy of our most current notice by calling us.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)
We may use and disclose your PHI for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, home care operations, and treatment.

- **Payment**. We use and disclose your PHI in order bill and collect payment for the services and items you may receive from us. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your health information to bill you directly or services and items.
- **Treatment.** We may use and disclose your PHI to coordinate services with other health care providers involved in your care. For example, we may collect measurements to identify appropriate seating and mobility system(s). We may obtain and disclose information on CPT diagnosis codes, diagnosis and prognosis, functional limitations, pre-existing health conditions, hospitalizations, prior use of equipment, and information specific to qualifying the patient as dictated by CMN / detailed written order forms.
- **Appointment Reminders**. We may use and disclose your health information to contact you and remind you of visits / deliveries / to ask whether you need additional supplies.
- **Release of information to Family / friends**. We may release your health information to a friend or family member that is helping you to pay for your health care, or who assists in taking care of you.
- **Disclosures Required by Law**. We will use and disclose your health information when we are required to do so by federal, state or local law. We require any business associates to protect the confidentiality of your information and to use the information only for the purpose for which the disclosure is made. We do not provide customer names and addresses to outside firms, organizations, or individuals except in furtherance of our business relationship with you or as otherwise allowed by law.

We restrict access to nonpublic information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your personal information.

OTHER PERMITTED OR REQUIRED DISCLOSURES
- **As Required by Law**. We must disclose PHI about you when required to do so by law.
- **Public Health Activities**. We may disclose PHI to public health agencies for reasons such as preventing or controlling disease, injury, or disability.
- **Victims of Abuse. Neglect, or Domestic Violence**. We may disclose PHI to government agencies about abuse, neglect, or domestic violence.
- **Health Oversight Activities**. We may disclose PHI to government oversight agencies. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- **Judicial and Administrative Proceedings**. We may disclose PHI in response to a court or administrative order. We may also disclose PHI about you in certain cases in response to a subpoena, discovery request, or other lawful process.

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- Law Enforcement. We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- To Avert a Serious Threat to Health or Safety. We may disclose PHI about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions**. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers Compensation**. We may disclose PHI to the extent necessary to comply with state law for workers'compensation programs.
YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)
You have certain rights regarding PHI that we maintain about you.
- **Right To Access Your PHI.** You have the right to review or obtain copies of your PHI records, with some limited exceptions. Usually the records include referral information, delivery forms, billing, claims payment, and medical management records. Your access to records can include PHI maintained electronically even if not an electronic health record. Your request to review and/or obtain a copy of your PHI records must be made in writing. We may charge a fee for the costs of producing, copying, and mailing your requested information, but we will *tell* you the *cost* in advance.
- **Right To Amend Your PHI.** If you feel that PHI maintained by us is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or you ask to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to Notification of Breach or Accounting of Disclosures**. You have the right to be notified following a breach of your unsecured PHI. This will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. It may also exclude certain other disclosures, such as for national security purposes. You will be notified of any unauthorized release or access to your PHI. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge for providing the accounting, but we will tell you the cost in advance.
- **Right To Request Restrictions on the Use and Disclosure of Your PHI**. You have the right to request that we restrict or limit how we use or disclose your PHI for services, payment, or health care operations. You may restrict disclosures of PHI if you have paid out-of-pocket in full for the health care item or service. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right To Receive Confidential Communications**. You have the right to request that we use a certain method to communicate with you or that we send information to a certain location. For example, you may ask that we contact you at work rather than at home. Your request to receive confidential communications must be made in writing. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have a right at any time to request a paper copy of this Notice. You may ask us to give you a copy of this notice at any time.
- **Contact Information for Exercising Your Rights**. You may exercise any of the rights described above by contacting our privacy Office.
- **Complaints**. If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Office of Civil Rights.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.
This Notice of Privacy Practices is effective as of December 20th, 2013

ACKNOWLEDGEMENT
I acknowledge receipt of Freedom Pharmacy' Notice of Privacy Practices. You may complete and mail to Freedom Pharmacy, 434 Hurricane Lane, Williston, VT 05495

Patient's Name: ______________________ Patient's DOB: ______________________

Address: ____

Phone Number: ______________________

Signature: ______________________ Date ______________

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Patient's Name: ______________________ Patient's DOB: ______________________

MEDICAL RELEASE

I authorize Freedom Pharmacy to release medical and billing in formation to the following (other than self or physician offices): LIST ALL

Name: ______________________

Address: ______________________

Name: ______________________

Address: ______________________

Name: ______________________

Address: ______________________

GUARANTEE OF PAYMENT

This is to certify that we, Freedom Pharmacy, will receive reimbursement from the guarantor listed below for prescriptionmedications, over-the-counter products, co-pays, administration fees and any non-covered medications/products/services for the patient listed above for products/services rendered.

☐ SEND BILLS TO PATIENT ☐ SEND BILLS TO GUARANTOR LISTED BELOW

Name of Guarantor: ______________________

Address of Guarantor: ______________________

Phone Number: ______________________

Guarantor Signature: ______________________ Date ____________

Regardless of whether or not the patient has prescription insurance benefits, the patient and/or guarantor (payee) will need to make payment arrangements in advance with our billing department in the form of a credit card or checking/savings account in order for services to start (see attached automatic payment form)

Patient Signature: ______________________ Date ____________

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Patient's Name: ____________________ Patient's DOB: ____________________

OPTION 1
AUTOMATIC ACH PAYMENT AUTHORIZATION

I (we) hereby authorize Pharmacy Direct Delivery, LLC (dba Freedom Pharmacy) to charge my bank account indicated below at the depository financial institution (my bank) named below, and to debit the monthly statement amount during the 1st week of each month.

Bank Name: ____________________ Type of account: ☐ CHECKING ☐ SAVINGS

Routing Number: ____________________ Account Number: ____________________

Signature: ____________________ Date ____________________

Printed Name: ____________________

OPTION 2
AUTOMATIC CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize Pharmacy Direct Delivery, LLC (dba Freedom Pharmacy) to automatically process my monthly statement charges during the 1st week of each month by way of my credit card (below), until written notification to the contrary is given.

Type of credit card: ☐ MASTERCARD ☐ VISA ☐ AMEX ☐ DISCOVER

Credit Card Number: ____________________ Exp. Date: __________ Security Code: ________

Name on Credit Card: ____________________ Email: ____________________

Credit Card Billing Address: ____________________

Signature: ____________________ Date ____________________

-By completing and executing this form, the cardholder acknowledges and agrees that Pharmacy Direct Delivery, LLC (hereafter “Company”) is authorized as of the authorization date set forth above and subject to the terms and conditions set forth below, to charge the credit card, debit card, charge card or other payment card (hereafter “credit card”), specified above for the amounts billed to the account holder or cardholder specified above for services and products provided. -Company will send the account holder or cardholder an invoice for services/products provided upon request. Company will charge the above credit card for the amount specified in the statement on the date of the statement. The accountholder/cardholder should ensure such charge will not cause the credit card account to exceed any established credit limits or available balances as on the date of charge. There will be a $25.00 penalty for any rejected charges pursuant to this authorization. Cardholder acknowledges that they will continue to be liable for any such rejected or any unpaid charges including all penalties. Cardholder further authorizes Company to initiate a charge or credit as necessary to correct any prior overpayment or underpayment of any invoice or any other charge or credit effected under this or prior authorization(s). Company and cardholder further acknowledge that if this payment authorization is for a recurring charge, then Company will inform cardholder of any variances in the recurring amount. Each charge will appear as a payment on the next statement to accountholder/cardholder after the charge date. Recurring charges will begin with the first statement we send the accountholder/cardholder after we receive this form.

-Note: The minimum charge for using Credit Cards is ten dollars ($10.00). If your monthly statement is less than $10.00, then a credit will be posted to your account.

-This authorization shall remain in effect until Pharmacy Direct Delivery, LLC receives in writing any changes in account information or termination of this authorization at least 15 days prior to the next billing date and Pharmacy Direct Delivery, LLC has had sufficient time to clear any arrears and act on the authorization. Cardholder will continue to be liable for any statements due and pending as of such termination. Cardholder is responsible for informing Company of any changes in the above information.

-If you have any questions on billing or credit card/ACH charges, please contact Pharmacy Direct Delivery, LLC , 434 Hurricane Lane, Williston, VT 05495, Tel: 802-655-3544, Fax: 802-655-0123