Heartland of the West

RESIDENT—PHARMACY AGREEMENT

Resident Legal Name:______________________________ ***Preferred Name (optional):*** ____________________

DOB:____________ ***Gender:***__________________ ***Community Name:***__________________________

All Information Must be Filled Out Prior to Guardian Pharmacy Providing Medications

BILLING INFORMATION

First and Last Name (please print)______________________________ Relation__________________

Address____ Apt/Rm#______________

City__________________________ State__________________ Zip Code______________

Phone Number____________________ Email__________________________ ☐ Online Statement Access

Name to release PHI to (please print)__________________________ Phone Number__________________

Check one of the following and fill out the information below: ☐ Self ☐ POA ☐ Legal Representative

Consent to Provide Services and Medical Records

I, ____________________________, authorize Guardian Pharmacy, (referred to this agreement as the "Pharmacy") to provide medications and associated products and services to the above named Resident. If signing this Agreement as an agent of the Resident pursuant to a Power of Attorney (POA), I certify that I have legal authority to sign this agreement on the Residents' behalf. I have provided the Community/Organization listed above with the most current and accurate medical records for the Resident (the "Records") and authorize the Community/Organization to provide the Pharmacy with all Records in its possession or control. I further acknowledge and approve that, when necessary, any information with the possession or control of the Community/Organization may be relayed to the Pharmacy through any secured means including, but not limited to verbal communications in person or over the phone or via secured email. By my signature, I also permit the Community/Organization to continue to notify and provide the Pharmacy with any records and medical changes needed to provide product and services to the above-named resident in the future until such permission is revoked in writing signed by the Resident or by me on the Resident's behalf. Where allowed by state law this agreement authorizes the Pharmacy to provide medication-synchronization services for the Resident.

Assignment of Benefits, Privacy Practices, Financial Agreement

I hereby request that payment of authorized insurance benefits be made on the Resident's or my behalf to the Pharmacy for medications, products and/or services furnished to the Resident or me. I authorize the Pharmacy to release any necessary or required personal health information to the Center for Medicare and Medicaid Services, any health insurance company, and/or their agents for the purpose of determining benefits or resolving any question regarding coverage. *AND* I hereby acknowledge that I have received a copy of the Pharmacy's Notice of Privacy Practices (HIPAA), Resident Rights & Responsibilities and understand each respective party's rights (see reverse of this page).

By signature below, I acknowledge the Resident, or whomever is named as the "Financial Responsible Party"/Legal Representative above, will be responsible to pay the usual and customary fee for all medications, products and services provided to the Resident by the Pharmacy at the direction of the facility administration and staff and attending physician(s). If I disagree with any medication, product or service directed by the facility or an attending physician, I will contact them and resolve the issue(s) and ask them to provide different written direction to the Pharmacy. I acknowledge and agree that the Pharmacy provides medications, products or services based upon the most current written direction received by it.

For Residents receiving benefits from an insurance company (referred to in this agreement as a Pharmacy Benefits Manager "PBM"), I am aware that the Pharmacy will bill the PBM for all medications, products and services covered by the PBM and that the Resident or Financial Responsible Party will be responsible for any co-payments that may apply and/or for the payment for all medications, products and services provided by the Pharmacy that are not covered by the PBM. Should home health and/or hospice services and supplies be arranged, I understand that Medicare will not reimburse the Resident or Financial Responsible Party or my supplier and the Resident or Financial Responsible Party will be responsible for those costs as well.

I also understand that in addition to billing the PBM, the Pharmacy will also bill the Resident or Financial Responsible Party on a regular basis (normally monthly) for all charges for services, medications and products Resident received. The invoice will show all charges billed, payments received, and any adjustments required to the Resident's account over the previous billing period, plus any balance forward. Full payment shall be made within 15 days of the date the monthly statement is issued. Any account balance over thirty (30) days past due shall accrue interest on the account balance and the late fee at the rate of 1.5% per month until paid in full. If the account balance has not been paid within sixty (60) days of any invoice, the Pharmacy has the option to discontinue providing additional medications, products or services to the above-named Resident. Regardless of whether the Pharmacy still provides medications, products or services to the Resident, if the Pharmacy is required to pursue legal action to collect any balance due on behalf of the Resident, the Financial Responsible Party shall pay reasonable attorney and collection agency fees and costs incurred in successfully collecting any amounts due and owing hereunder.

I will remit payment in full upon transfer of any prescriptions. I understand that the Pharmacy can provide for regular automatic payments from an established checking or savings account or to a credit card. If I elect an automated payment method, I will sign a separate authorization form, but understand that the terms and conditions of this agreement will still apply. Any account that has a payment returned for insufficient funds or closed account will receive a twenty-five dollar ($25.00) fee.

Signature X______________________________________ Date__________________

Signer must be the same as the "I" line.

3250 East 17th Street, Idaho Falls, ID 83406 • Ph (208) 552-7677 • Fax (208) 552-2098
8455 W. Emerald Street, Boise, ID 83704 • Ph (208) 323-0067 • Fax (208) 323-5954
8599 Prairie Trail Drive, Ste A 300, Englewood, CO 80112 • Ph (303) 248-7920 • Fax (303) 889-5158
160 N. Cutler Drive, No. Salt Lake, UT 84054 • Ph (385) 324-2508 • Fax (833) 734-1433

RETURN TOP COPY TO PHARMACY • RETAIN A COPY FOR YOUR RECORDS

Guardian Pharmacy Services
Heartland of the West

NOTICE OF PRIVACY PRACTICES
9/23/2013

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.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Pharmacy has created this Notice of Privacy Practices. This Notice describes the Pharmacy's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Pharmacy protect the privacy of your PHI that the Pharmacy has received or created.

This Pharmacy will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Pharmacy will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. The Pharmacy reserves the right to change the Pharmacy's privacy practices and this Notice.

HOW THE PHARMACY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Pharmacy is permitted, by law, to use and disclose your PHI.

Uses and disclosures of PHI for Treatment: We will use the PHI that we receive about you to fill your prescription and coordinate or manage your health care. The Pharmacy may disclose PHI about you to doctors, nurses, technicians, caregivers, or other personnel who are involved in your care. The Pharmacy may disclose PHI about you to other entities or individuals outside the pharmacy who may be involved in your medical care in order to assist in the continuum of care to you after you choose to no longer utilize the pharmacy's services.

Uses and disclosures of PHI for Payment: The Pharmacy will disclose your PHI to obtain payment or reimbursement from insurers and other financial responsible parties for your health care services.

Uses and disclosures of PHI for Health Care Operations: The Pharmacy may internally use your PHI to conduct quality assessments, improvement activities, and evaluate the Pharmacy workforce.

The following is an accounting of additional ways in which the Pharmacy is permitted or required to use or disclose PHI about you without your written authorization.

Uses and disclosures as required by law: The Pharmacy is required to use or disclose PHI about you as required and as limited by law.

Uses and disclosure for Public Health Activities: The Pharmacy may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.

Uses and disclosure about victims of abuse, neglect or domestic violence: The Pharmacy may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.

Uses and disclosures for health oversight activities: The Pharmacy may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.

Disclosures to Individuals Involved in your Care: The Pharmacy may disclose PHI about you to individuals involved in your care. You have the right to tell us to share information with your family, close friends, or others involved in your care. If you are not able to tell us your preference, for example if you are unconscious, we may 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.

Disclosures for judicial and administrative proceedings: The Pharmacy may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Pharmacy.

Disclosures for law enforcement purposes: The Pharmacy may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.

Uses and disclosures about the deceased: The Pharmacy may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes: The Pharmacy may use and disclose PHI for the purpose of procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.

Uses and disclosures for research purposes: The Pharmacy may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Pharmacy will request a signed authorization by the individual for all other research purposes.

Uses and disclosures to avert a serious threat to health or safety: The Pharmacy may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

Uses and disclosures for specialized government functions: The Pharmacy may use or disclose PHI about you for specialized government functions including; military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

Disclosure for workers' compensation: The Pharmacy may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

Disclosures for disaster relief purposes: The Pharmacy may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

Disclosures to business associates: The Pharmacy may disclose PHI about you to the Pharmacy's business associates for services that they may provide to or for the Pharmacy to assist the Pharmacy to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

OTHER USES AND DISCLOSURES

The Pharmacy may contact you for the following purposes:

Information about treatment alternatives: The Pharmacy may contact you to notify you of alternative treatments and/or products.
Health related benefits or services: The Pharmacy may use your PHI to notify you of benefits and services the Pharmacy provides.
Fundraising: If the Pharmacy participates in a fundraising activity, the Pharmacy may use demographic PHI to send you a fundraising packet, or the Pharmacy may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt-out of all future fundraising activities.

FOR ALL OTHER USES AND DISCLOSURES

The Pharmacy will obtain a written authorization from you for all other uses and disclosures of PHI, and the Pharmacy will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact the appropriate HIPAA Contact listed below to obtain a Request for Restriction of Uses and Disclosures.

YOUR HEALTH INFORMATION RIGHTS

The following are a list of your rights in respect to your PHI. Please contact the HIPAA Contact Person for more information about the below.
Request restrictions on certain uses and disclosures of your PHI: You have the right to request additional restrictions of the Pharmacy's uses and disclosures of your PHI; however, the Pharmacy is not required to accommodate a request. This includes the right to restrict disclosures to Insurances for those products and services you pay out-of-pocket for.
The right to have your PHI communicated to you by alternate means or locations: You have the right to request that the Pharmacy communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Pharmacy to have an accurate address and phone number in case of emergencies. The Pharmacy will consider all reasonable requests.
The right to inspect and/or obtain a copy of your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Pharmacy for the duration the Pharmacy maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges, if any.
The right to amend your PHI: You have the right to request an amendment of the PHI the Pharmacy maintains about you, if you feel that the PHI the Pharmacy has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.
The right to receive an accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the Pharmacy.
The right to receive additional copies of the Pharmacy's Notice of Privacy Practices: You have the right to receive additional paper copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically
Notification of Breaches: You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Pharmacy reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Pharmacy will also post the revised version of the Notice in the Pharmacy.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Pharmacy and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Pharmacy, please contact the Director of Operations at the pharmacy. Contact information for each location is provided below. If you wish to file a complaint with the Secretary, please write to: https://www.hhs.gov/ocr/about-us/index.html. The Pharmacy will not take any adverse action against you as a result of your filing of a complaint. If you have a complaint please contact the pharmacy. If you are not satisfied with the complaint resolutions, you may contact The Compliance Team at 888-291-5353.

HIPAA Contact Information

If you have any questions on the Pharmacy's privacy practices or for clarification on anything contained within the Notice, please contact:

Guardian Pharmacy—Idaho Falls
3250 East 17th Street
Idaho Falls, ID 83406
(208) 552-7677

Guardian Pharmacy—Boise
8455 W. Emerald Street
Boise, Idaho 83704
(208) 323-0067

Guardian Pharmacy—Denver
8599 Prairie Trail Drive, Ste A 300
Englewood, CO 80112
(303) 248-7920

Guardian Pharmacy—Utah
160 N. Cutler Drive
No. Salt Lake, UT 84054
(385) 324-2508