ATHENS INFUSION & PHARMACY

1135 Cedar Shoals Drive, Building 6, Athens, GA 30605
Phone: 706-369-0583 | Fax: 706-369-9592

CHARGE ACCOUNT INFORMATION

Resident Name: _____ Birth Date: _____

Please circle: Male / Female Social Security No: _____ Allergies: _____

Next of Kin: _____

Send bills to: _____

Relationship to Patient: _____

Billing Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Assisted Living Facility: _____

Assisted Living Facility Street Address: _____

City: _____ State: _____ Zip Code: _____

PRESCRIPTION INSURANCE INFORMATION *(A copy of the actual card must be furnished)*

Insurance Company Name: _____

Policy Holder Name: _____ Relationship to Cardholder: _____

Policy/ID #: _____ Group #: _____

Medicare #: _____ Medicaid #: _____

Rx BIN: _____ PCN: _____

I hereby agree to accept responsibility for the pharmacy charges incurred on behalf of this resident. I understand that all prescription insurance information is needed prior to admission in order for Athens Infusion & Pharmacy to submit the prescription drug charges to the appropriate insurance company, provided we are a participating pharmacy. Statements are mailed around the first of each month. All bills are due and payable upon receipt. Past due balances of 60 days or more are subject to a finance charge of 7% per month and may also be subject to discontinuation of pharmacy services until the account it brought current. There is a $30.00 charge on returned checks. Delinquent accounts that are turned over for collection are subject to an attorney's fee of 30% of the outstanding balance referred to the attorney and all other costs of collection.

_____ _____

Signature of Responsible Party **Date Signed**

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RE-PACKAGING WAIVER OF LIABILITY

Resident Name: _____ Assisted Living Facility: _____

I understand that I am requesting Athens Infusion & Pharmacy to repackage my medications from their original mail order containers into a multi-dose system. Athens Infusion reserves the right to refuse to repack medication when manufacturer's guidelines prohibit them from doing so. I realize that Athens Infusion & Pharmacy is not providing a depiction of what medication is being dispensed or its accuracy. I hold Athens Infusion & Pharmacy harmless and take full responsibility. Due to State of Georgia Pharmacy regulations, we will not be able to accept any samples or over-the-counter medications for the purpose of repackaging. **These clients will also be charged the $5.00 per drug handling fee with a minimum of $20.00 per month.** I also agree to be responsible for supplying all medications to be repackaged and providing it to Athens Infusion & Pharmacy in a timely manner to ensure a continuous medication regimen.

I agree to allow Athens Infusion & Pharmacy to dispense and bill for any necessary medication should the need arise, such as:
A) new medication order which has not been supplied by the family
B) there is insufficient medication to fill cassettes at the time of repackaging

MID-MONTH MEDICATION CHANGES

Any changes made during the monthly drug cycle of this resident in which Athens Infusion & Pharmacy is required to repackage any medication due to dosing changes will be subject to a fee of $5.00 per drug handled as well as delivery fees.

PHARMACY FINANCIAL AGREEMENT

_____ (Resident) & _____ (Responsible Party) understand that Athens Infusion & Pharmacy will provide medications and other supplies requested by the physician &/or assisted living facility personnel. The responsible party will be accountable for payment of these items ordered. Athens Infusion & Pharmacy differs in many ways from a retail pharmacy. Instead of receiving payment at the time of service we offer a courtesy charge account to the responsible party for each resident. We ask that each responsible party provide us with a social security number for the sole purpose of issuing this charge account. If you refuse to provide this information, a credit card will be required to remain on file with Athens Infusion & Pharmacy. A copy of this card must also be provided. You will still receive a statement on a monthly basis, and we will only charge to this credit card when you call and authorize us to do so. However, in the event that your account becomes 90 days past due, Athens Infusion & Pharmacy assumes the right to charge the full balance due on that account to the charge card on file.

Athens Infusion & Pharmacy's monthly billing cycle ends on or around the 20th of each month. We understand that payment is due upon receipt of statement. Interest may be charged on all balances 30 days or more past due

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at 7% periodic rate with a minimum of $1.00. Please understand that in order for medication and supplies to continue to be provided, the account must remain current and any balance of 60 days past due may be subject to discontinuation of our pharmacy service. Service may resume once account is made current.

CREDIT CARD INFORMATION

Number: _____

Mastercard _____ Visa_____ Expiration Date: _____

Security Code: _____ Billing Zip Code: _____

I, _____ (Responsible Party) authorize Athens Infusion & Pharmacy to charge the credit card listed above for charges incurred to _____ (Resident Name). In the event that the account becomes 90 days past due, Athens Infusion & Pharmacy has the right to charge the full amount to the credit card number on file.

_____ _____ _____

Responsible Party's Signature **Responsible Party's Social Security #** **Date**

FEES FOR ASSISTED LIVING FACILITIES

There is a fee of _____ per month for each resident of _____ (Facility). This fee is assessed each month to cover expenses for delivery, medication management audits and repackaging charges. No additional repackaging fees will be assessed for these patients.

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LIST OF CURRENT MEDICATIONS

Please include all prescriptions and over-the-counter medications.

Physician Name: _____ Phone #: _____

Physician Name: _____ Phone #: _____

Physician Name: _____ Phone #: _____

Previous Pharmacy Name: _____ Phone #: _____

MEDICATION NAME	STRENGTH	AMOUNT PER DOSE	FREQUENCY	ADMINISTRATION TIMES	DOCTOR
Example Drug	*40mg*	*2 tablets*	*Twice daily*	*8am, 8pm*	*Dr. Smith*

Additional Comments (if needed):

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NOTIFICATION OF INFORMATION PRACTICES

The purpose of the consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of the provider or organization.

YOUR CONSENT

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among my diagnosis/es and other health information to my bill(s).
- A source of information for applying my diagnosis/es and other health information to my bill(s).
- A means by which my health plan or health insurance company can verify that services billed were
- actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care and competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and discloses by Athens Infusion & Pharmacy;
- I have the right to review the Notice of Information Practices prior to signing this consent;
- Athens Infusion & Pharmacy can change its Notice of Information Practices but notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that Athens Infusion & Pharmacy is not required to agree to those restrictions;
- Any restrictions to which Athens Infusion & Pharmacy agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that Athens Infusion & Pharmacy can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment,

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payment for service, or for the health care operations of Athens Infusion & Pharmacy, please do so after reading the Notice of Information Practices. You may use this consent form to request a restriction.

For provider use only:

Restriction is

- ☐ Accepted
- ☐ Denied

Reason denied:

Patient is notified?

- ☐ Yes
- ☐ No

I request the following restrictions to the use or disclosure of my health information:

_____

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Information Practices.

_____ _____

Signature of Patient or Legal Representative **Witness**

_____ _____

Date **Effective Date**

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ASSIGNMENT OF BENEFITS (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Athens Infusion & Pharmacy for medical supplies and/or medication(s) furnished to me by Athens Infusion & Pharmacy.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
4. Athens Infusion & Pharmacy to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
5. Athens Infusion & Pharmacy to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

_____ _____

Signature of Patient or Legal Representative **Date Signed**

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Athens Infusion & Pharmacy for any medical supplies and/or medications furnished to me by Athens Infusion & Pharmacy. I authorize any holder of medical information about me to release to Athens Infusion & Pharmacy, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

Medicare Number: _____ Insurer (in addition to Medicare): _____

Policy Number: _____

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NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you may be used and disclosed and how you can obtain access to your identifiable health information.

OUR COMMITMENT TO YOUR PRIVACY:

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time. To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. 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 our practice has 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 offices in a prominent location, and you may request a copy of our most current notice during any office visit.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Bldg. 6, Athens, GA 30605. 706-369-0583

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your identifiable health information:

1. **Treatment**. Our organization may use your identifiable health information to treat you. For example, we may perform a follow-up interview and we may use the results to help us modify your treatment plan. Many of the people who work for our organization may use of disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children, or parents.
2. **Payment**. Our organization may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties who may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.
3. **Health Care Operations**. Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders**. Our organization may use and disclose your identifiable health information to contact you and remind you of visits/deliveries.
5. **Health-Related Benefits and Services**. Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.
6. **Release of Information to Family/Friends**. Our organization may release your identifiable health information to a friend or family member who is helping you pay for your health care of who assists in taking care of you.
7. **Disclosures Required By Law**. Our organization will use and disclose your identifiable health information when we are required to do so by federal, state, or local law.

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USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks**. Our organization may disclose your identifiable health information to public health authorities who are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury, or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals if a product or device they may be using has been recalled
    - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our organization may disclose your identifiable health information to a health oversight agency for activities authorized by law. 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.
3. **Lawsuits and Similar Proceedings**. Our organization may use and disclose your identifiable health information in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement**. We may release identifiable health information if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe might have resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena, or similar legal process
    - To identify/locate a suspect, material witness, fugitive, or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Serious Threats to Health or Safety**. Our organization may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
6. **Military**. Our organization may disclose your identifiable health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.
7. **National Security**. Our organization may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates**. Our organization may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution; and/or (c) to protect your health and safety or the health and safety of other individuals.
9. **Workers' Compensation**. Our organization may release your identifiable health information for workers' compensation and similar programs.

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YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request:

1. to Compliance Officer, **Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583** specifying the requested method of contact or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your identifiable health information for the treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of disclosure of your identifiable health information, you must make your request in writing to **Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583**. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both; and (c) to whom you want the limits to apply.
3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing **Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583** in order to inspect and/or obtain a copy of your identifiable health information. Our organization may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to **Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583**. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or
   (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures**. All of our patients have the right to requests an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to **Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583**. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583**.
7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our

organization, **Compliance Officer, Athens Infusion & Pharmacy, 1135 Cedar Shoals Drive, Building 6, Athens, GA 30605, 706-369-0583**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures**. Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note that we are required to retain records of your care.

PATIENT RIGHTS & RESPONSIBILITIES

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care, may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify Athens Infusion & Pharmacy of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should Notify Athens Infusion & Pharmacy in such incidence.
3. The patient should promptly notify the Athens Infusion & Pharmacy of any changes to their address or telephone.
4. The patient should promptly notify the Athens Infusion & Pharmacy Athens Infusion & Pharmacy of any changes concerning their physician.
5. The patient should notify the Athens Infusion & Pharmacy of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.