Neighborhood LTC Pharmacy

Patient Intake Information Sheet

1265 South Cotner Blvd Ste 30
Lincoln NE 68510

Personal Information

Name of Patient: ______________________________DOB: ______________SS#: ____________________ M/F

Delivery Address:______________________________City:______________State______Zip:________

Phone Number:_____________________________ Alt Phone Number:_________________________________

Insurance Information – Please have originals available for copying

Medicaid Medicare Private Insurance Other __________________

Medicare#: ____ Medicaid ID: ________________________________

ID#: ____ Group: _________________________________

Relationship to Cardholder: _____________________________________

Medical Information

PCP: ____

Other Physicians:____

Drug Allergies ____

Delivery Information

Filling Information – Start Date: __________ Delivery Day:______________ Frequency:_____________

Service Level (circle one): Standard / Preferred

Iacknowledge receipt of Patient Rights & Responsibilities and the Notice of Privacy Practices provided by the Pharmacy.

Patient Signature: ____ **Date:** __________

Responsible Party Signature: _______________________________________ **Date:** __________

Patient Name: ______________________________

Medication Name & Strength	Directions	Time of Administration	Doctor

Unless otherwise indicated, I authorize a month's supply with 12 months of refills (6 months on controls).

Provider Signature: ____ **Date:** ______________________

Patient Name:____________________________

Choose one of the following methods of payment:

Here's How Recurring Payments Work: You authorize regularly scheduled charges to your Visa, MasterCard, American Express, Discover card or e-checking account payment. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided if the total payment is under_____________. You recognize that the amount due may vary. If your bill is more than that amount, you will receive notice from us prior to the payment being collected.

Please complete the information below:

I ______________________________ authorize Neighborhood LTC Pharmacy to charge my credit card or automatically
(full name)

withdraw funds from my bank account as indicated below by the 15th on each month.

Account holder's mailing address as it appears on correspondence from Credit Card Company or Bank:

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________ (REQUIRED)

* ***Credit Card Recurring Payment Authorization Form***

Account Type: Visa MasterCard Discover

Cardholder Name ____

Account Number ____

Expiration Date ____________

CVV (3 digit number on back of Visa/MC/Discover) ______

* ***ACH Recurring Payment Authorization Form***

Account Type: Checking Savings

Name on Acct ____________________________

Bank Name ____________________________

Bank Routing # ____________________________

Account # ____________________________

Bank City/State ____________________________

I authorize the Pharmacy to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

SIGNATURE ____________________________________ DATE __________________

REQUEST TO DISCLOSE PATIENT HEALTH RECORDS TO INDIVIDUALS OR ENTITIES OTHER THAN THE PATIENT

Please complete the information below to request any person or entity you would like us to disclose your health records to. ***Please indicate if you wish to have financial information disclosed as well***. The Facility will add this request to your file. Please note that you may amend your request at any time and that the Facility will review your request and notify you as to whether your request has been approved or denied.

Patient Name	Date of Birth
Address	Telephone #

Please provide us with any persons or entities you would like us to disclose personal health record and/both/or financial information at their request. (Please use the back of this form is more space is needed)	
I wish to add: ______________________ ______________________ ______________________ ______________________	Please disclose the following information: _______ Patient records _______ Financial and accounting information _______ Other ________ I do not wish to add anyone at this time but I can amend my record at any time in the future. The Facility will notify me as to the approval and denial of such request.

Patient/Personal Representative Signature	Date

Printed Name if Not the Patient	Relationship

When completed, please return to Neighborhood LTC Pharmacy
Or Mail to:
Neighborhood LTC Pharmacy
1265 S Cotner Blvd #30
Lincoln, NE 68510

Internal Use Only	
Received and Reviewed by (Print)	Date
Request has been accepted and documented in patient files.	

1265 S Cotner Blvd #30
Lincoln, NE 68510
Phone: 402-488-1184
Fax: 402-488-1187

PHARMACY

Customer Satisfaction Survey

Patient:______________________ **Date of Service:______________**

Phone#: _____________________

		yes	no	n/a
1.	Responses to questions concerns were addressed in a timely manner.			
2.	Service friendly prompt and courteous.			
3.	Satisfied with the time spent with the Pharmacist.			
4.	Did Pharmacists/Staff request info on other medications currently prescribed?			
5.	Satisfied with medication counseling/instructions provided by the pharmacist.			
6.	Satisfied with the length of time for prescription processing.			
7	Satisfied with services. Would recommend to others.			
8	How did you hear about us? Referral, newspaper television, other:			

COMMENTS:

Employee Signature_________________________________ **Date of survey**______________

Neighborhood LTC Pharmacy
Customized Medication Packaging

Service Essentials

To Start

- Patient must fill 5 or more monthly packaged prescription medications to qualify for Basic packaging at no charge
- For medication profiles not meeting the minimum above, a $15 fee will apply for each medication short to be billed monthly. Example: Patient has 3 prescription medications in the med-pack. A $30 charge will apply each month.
- Pharmacy does not repackage medications unless patient is a veteran of the US Armed Forces
- A VA Repackage Fee of $15 per medication will be accessed monthly capped at $75. Pharmacy cannot repackage controlled substances.
- Pharmacy does not repackage over the counter items in any case
- Delivery options: Home, Office, Mail, or Pick Up

Payment:

- Enroll in monthly auto-pay with a ACH or Credit Card
- Pay Copays and Fees upon delivery

New Medications or Changes:

- New medications will be sent out in a bottle to coincide with the start date of the next cycle of medication packs.
- Medication changes that require the med pack to be updated will need to be brought into the pharmacy for the change to be made. This includes a new label on all packs and the correct medications added or discontinued from each dosing schedule.

Med-Pack Dispensing Options

Standard Option: $0 monthly fee which includes:

1. Requires dispensing of 28 days' supply of medications
2. Med-Pack changes brought into the pharmacy will be $5 per change

Preferred Option: $25 monthly flat fee which includes:

1. 7 day or 28 days' supply of medications dispensed
2. Unlimited medication changes to bubble pack

Bill of Rights and Responsibilities

Home care clients have a right to be notified in writing of their rights and obligations before treatment is begun. The client's family or guardian may exercise the client's rights when the client has been judged incompetent. Home care providers have an obligation to protect and promote the rights of their clients, including the following rights.

Client Rights:

- Be treated with dignity, courtesy and respect.
- Be fully informed upon admission of the company's policies, procedures, ownership or control of the local facility and the process for receiving, reviewing and resolving your complaints or concerns.
- Receive complete explanations of charges for services and equipment, including eligibility for third-party reimbursement and an explanation of all forms you are requested to sign.
- Receive quality equipment, supplies and services that meet or exceed professional and industry standards regardless of race, religion, political belief, sex, social status, age or disability.
- Receive equipment, supplies and services from qualified personnel and to receive instructions on self-care, safe and effective operation of equipment and your responsibilities regarding equipment, supplies and services, without discrimination in accordance with your physician orders.
- Participate in decisions concerning the nature and purpose of any technical procedure which will be performed and who will perform it, the possible alternatives and/or risks involved and your right to refuse all or part of the services and to be informed of expected consequences of any such action.
- Confidentiality of all your records (except as otherwise provided for by law or third-party payer contracts) and to review and even challenge those records and to have your records corrected for accuracy.
- Express dissatisfaction and to suggest changes in any service without discrimination, reprisal or unreasonable interruption of services.
- Be advised of the telephone number of the Medicare "Fraud Hot Line" is 1-800-638-6833, and the **NE State Board of Pharmacy is 402-471-2118 or the Compliance Team at 888-291-5353**.
- Participate in the planning of the care and in planning changes in the care, and to be advised that you have the right to do so.
- Accept or refuse medical treatment while competent and to make decisions about care/services to be received should you lose competency.
- Able to identify company personnel through proper organizational identification badges or cards.
- Be informed of any financial benefits when referred to an outside organization.
- Be informed of client rights under state law to formulate advanced care directives.

Client Responsibilities:

- Adhere to the plan of care or service established by their physician.
- Participate in the development of an effective plan of care.
- Provide medical and personal information necessary to plan and provide services.

  Be available at the time deliveries are made and to allow a **Neighborhood LTC Pharmacy,Inc** representative to enter their residence at reasonable times to repair or exchange equipment or to provide care.
- Notify the company if he/she is going to be unavailable.
- Treat company personnel with respect and dignity without discrimination.
- Provide a safe environment for staff to provide care and services.
- Care for and safely use equipment, according to instructions provided, for the purpose it was prescribed and only for/on the client for whom it was prescribed. Monitor the quantity of oxygen, nutritional products, and supplies in their homes and reorder as required to assure timely delivery of the required items.
- Protect equipment from fire, water, theft or other damage. The client agrees not to transfer or allow his/her equipment to be used by any other person without prior written consent of the company and further agrees not to modify or attempt to make repairs of any kind to the equipment.
- Except where contrary to federal or state law, the client is responsible for equipment rental and sale charges which the client's insurance company or companies does not pay. The client is responsible for settlement in full of his/her accounts.
- The company should be notified of any changes in the client's physical condition, physician's prescription or insurance coverage. Notify the company immediately of any address or telephone changes whether temporary or permanent.

NOTICE OF PRIVACY PRACTICES – Neighborhood LTC Pharmacy

Revised June 20/2014

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 Facility has created this Notice of Privacy Practices (Notice). This Notice describes the Facility'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 Facility protect the privacy of your PHI that the Facility has received or created.

This Facility 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 Facility 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 Facility reserves the right to change the Facility's privacy practices and this Notice.**

HOW THE FACILITY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Facility 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 from you to fill your prescription and coordinate or manage your health care.
Uses and disclosures of PHI for Payment: The Facility will disclose your PHI to obtain payment or reimbursement from insurers for your health care services.
Uses and disclosures of PHI for Health Care Operations: The Facility may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Facility workforce.

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

Uses and disclosures as required by law: The Facility is required to use or disclose PHI about you as required and as limited by law.
Uses and disclosure for Public Health Activities: The Facility 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 Facility 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 Facility 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 Facility may disclose PHI about you to individuals involved in your care.
Disclosures for judicial and administrative proceedings: The Facility may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Facility.
Disclosures for law enforcement purposes: The Facility 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 Facility 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 Facility 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 Facility 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 Facility 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 Facility 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 Facility 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 Facility 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 Facility 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 Facility may disclose PHI about you to the Facility's business associates for services that they may provide to or for the Facility to assist the Facility 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 Facility may contact you for the following purposes:

Information about treatment alternatives: The Facility may contact you to notify you of alternative treatments and/or products.
Health related benefits or services: The Facility may use your PHI to notify you of benefits and services the Facility provides.
Fundraising: If the Facility participates in a fundraising activity, the Facility may use demographic PHI to send you a fundraising packet, or the Facility 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 Facility will obtain a written authorization from you for all other uses and disclosures of PHI, and the Facility 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 Scott S. Louderback 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 Scott S. Louderback 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 Facility's uses and disclosures of your PHI. The Facility is not required to accommodate a request, except that the Facility is required to agree to a request to restrict disclosures to health insurance plans related to 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 Facility communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Facility to have an accurate address and home phone number in case of emergencies. The Facility will consider all reasonable requests.

The right to inspect and/or obtain a copy your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Facility for the duration the Facility 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 Facility maintains about you, if you feel that the PHI the Facility 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 Facility.

The right to receive additional copies of the Facility'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 Facility 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 Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact Scott S. Louderback. The pharmacy will respond within 5 calendar days. In the event your compliant is not resolved to your satisfaction you can contact our accrediting organization The Compliance Team at www.thecompliancedteam.org or by calling 1-888-291-5353. If you wish to file a complaint with the Secretary, please write to:

http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

The Facility will not take any adverse action against you as a result of your filing of a complaint.

CONTACT INFORMATION

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

Neighborhood LTC Pharmacy, Inc.
Scott S. Louderback
1265 S Cotner Blvd #30
Lincoln, NE 68510
(402) 488-1184