



CUSTOM **Rx** SHOPPE
PHARMACY

Confidential

Patient Information

Personal Information

Name _____

Sex M____ F _____

Address _____

Primary Insurance _____

****Please provide card**

ZIP _____

Relationship to Cardholder _____

Phone: (____) _____

Social Security Number _____

Date of Birth _____

Primary Care Physician _____

☐

Check here if this is for veterinary prescriptions only (skip next section).

Health Conditions-Please Circle All That Apply

None
Angina
Arteriosclerosis
Arthritis
Asthma
Blood clotting disorders
Breast Feeding/Pregnancy
Cancer
Cardiovascular Disease
Depression
Diabetes
Epilepsy/Seizures
Glaucoma
Migraine Headaches
High Blood Pressure
Osteoporosis
Parkinson's Disease
Pregnancy/Breast Feeding
Thyroid Disease
Ulcers
Other _____

Known Allergies and Drug Reactions

None
Aspirin
Cephalosporins (ex. Keflex)
Codeine
Erythromycin
Penicillin
Sulfa Drugs
Tetracycline
Other _____

List any non-prescription drugs you are using on a regular basis:

None
Aspirin/other anti-inflammatories
Antacids
Diet aids
Laxatives
Nasal Sprays
Sleep Aids
Vitamins
Other _____

Signature _____

Date ____/____/____



CUSTOM **R_x** SHOPPE
PHARMACY

Prescription Billing Information

In order for Custom Prescription Shoppe to make a smooth transition as your preferred pharmacy provider, we need the following information:

Resident Name: _____

Resident Social Security # _____ Date of Birth _____

Community/Facility: _____

Insurance/Payment Information (*we **must** have a copy of the front and back of the insurance card*):

☐ Private Pay ☐ VA ☐ Group Health Private

☐ Welfare / DSHS Pic Code

☐ Private Insurance Company

☐ Medicare #

Policy Number

☐ Other -

Member Id

☐ Other -

Responsible Party and Release of Medical Information

I understand that I am financially responsible to Custom Prescription Shoppe, LLC for all charges incurred by the above named resident including collection fees, attorney fees, and court costs. If the resident has state Medicaid, all non-covered medications and supplies will be billed to the resident, unless prohibited by regulations. I understand that I am responsible for payment of any medication or other charges to the above named resident not covered by third party insurance while he/she resides at this facility.

Statement balances will be paid immediately upon receipt unless other arrangements are made. If the amount is not paid in full within thirty (30) days of the due date, a late charge may be incurred, computed at one percent (1%) of the unpaid balance for each month, or part thereof, that is not paid in full. If the balance is not paid in full within thirty (30) days or a payment plan has not been arranged and agreed upon, provision of medications and supplies may be suspended.

I hereby authorize any holder of medical and/or insurance information about the above named resident to disclose such information to Custom Prescription Shoppe. I further authorize Custom Prescription Shoppe to disclose any medical and/or insurance information concerning above named resident in its possession to other professional personnel involved in patient care such as physician, a registered nurse, a pharmacist or other such personnel, and to any insurer or other third-party payer who maybe responsible to Custom Prescription Shoppe. Any disclosures will be made in compliance with HIPAA guidelines and other state and federal regulations.

Responsible Party _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell phone (_____) _____

Is this where to send the statement? _____

Relationship to Resident: __self__ spouse __son/daughter guardian __other__

Signed _____ **Date** _____

Many find credit card billing to be efficient and convenient. please contact us if you are interested in setting this account up for automatic credit card payments.

5917 PORTAL WAY
FERNDAL WA 98248
PHONE: 360-685-4282
FAX: 360-685-4283



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PHARMACY

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Consent to Receipt of Medications in Non-Child Resistant Containers

Patient name: _____ Date of Birth: _____

I, _____, hereby authorize and agree that all medications provided to me shall be delivered and received in a non-child-resistant container.

Patient signature: _____ Dated: _____

or Patient's Representative signature: _____ Dated: _____

Note: WAC 246-869-230 states that all legend drugs intended for oral use shall be dispensed in a child resistant container (CRC) as required by federal law or regulation, unless authorization to use a non-CRC is obtained from the prescriber, patient or patient's representative.



Name: _____ DOB: _____

Delivery Authorization

In order for Custom Prescription Shoppe to begin delivery services of your medications, we need the following information:

Address: _____

Is this where we will deliver your medications? _____

Delivery Address (if different from above): _____

Phone # at Delivery address: _____

Special Delivery Instructions: _____

Authorization to Discuss Pharmacy services:

By signing below, I do hereby authorize Custom Prescription Shoppe to discuss my prescription needs and payment information with the following individuals:

_____	_____
Name and phone number of person authorized	relationship

_____	_____
Name and phone number of person authorized	relationship

_____	_____
Name and phone number of person authorized	relationship

Customer Signature: _____ Date: _____



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Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge that I have received a copy of the pharmacy's Notice of Privacy Practices:

Printed name: _____ DOB: _____

Signature: _____ Date: _____
(Customer or legal guardian)

Documentation of Good Faith Effort

The pharmacy made a good faith effort to obtain a written acknowledgement of the individual's receipt of the Notice, but a written acknowledgement was not received for the following reason:

____ Individual refused to sign

____ Individual was not able to sign. (Please specify below)

____ Emergency

____ other (Please specify below)

EFFECTIVE 10/1/2003

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 (Notice). 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, 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.** Revisions to the Notice will be posted in the pharmacy and upon your request, provided to you in a paper format.

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 from you to fill your prescription and coordinate or manage your health care.

Uses and disclosures of PHI for Payment: The pharmacy 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 pharmacy may use the minimum necessary amount of 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. All uses and disclosures will be to the minimum necessary amount of your PHI. Many of these uses and disclosures will never be made by the pharmacy; however, we are required by law to notify you of them as a health care provider.

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 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: [Only include veteran's activities if the pharmacy is a component of the department of Veterans Affairs. Only include department of state functions if the pharmacy is a component of the department of state.]

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.

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:

Notice of Privacy Practices

Refill reminders: The pharmacy may contact you to remind you of your prescription upon such time they are ready to be refilled.

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.

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 Sarah Pitts 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.

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. If you wish to request additional restrictions, please obtain the form, *Request for Restriction of Uses & Disclosures*, from the pharmacy and return the completed form to the pharmacy or return to Sarah Pitts.

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 home phone number in case of emergencies. The pharmacy will consider all reasonable requests. If you wish to request a change in your communicating address and/or phone number, please obtain a form, *Request for Alternative Arrangements for Confidential Communication*, from the pharmacy and return the completed form to the pharmacy or return to Sarah Pitts.

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 pharmacy for the duration the pharmacy maintains PHI about you. If you wish to inspect or obtain a copy of your PHI, please obtain a form, *Request for Access to Records*, from the pharmacy and return the completed form to the pharmacy or return to Sarah Pitts. 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. If you wish to amend your PHI files, please obtain a form, *Request for Amendment to PHI*, from the pharmacy and return the completed form to the pharmacy or return to Sarah Pitts.

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. If you wish to receive an accounting of disclosures of your PHI, please obtain a form, *Request for Accounting of Disclosures*, from the pharmacy and return the completed form to the pharmacy or return to the Sarah Pitts. You should be aware, however, that such an accounting excludes uses and disclosures made for treatment, payment, or health care operations purposes.

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. If you wish to receive a paper copy of this request, please ask a pharmacy workforce member and they will provide you with a copy.

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 revised Notice will be available, upon request, to all individuals. 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 Sarah Pitts. If you wish to file a complaint with the Secretary, please write to:

The U.S. Department of Health and Human Services
Office of the Inspector General
200 Independence Ave, S.W.
Washington, D.C. 20201

The pharmacy 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 pharmacy's privacy practices or for clarification on anything contained within the Notice, please contact:

The Custom Prescription Shoppe LLC.
Sarah Pitts
5917 Portal Way
Ferndale, WA 98248
(360) 685-4270