Lacey's LTC (Long Term Care) Pharmacy

4469 Lemon Street

Acworth, Georgia 30101

Phone: 678-236-0400 Fax: 678-236-0404

!!!!!!!!! IMPORTANT!!!!!!!!!

INSURANCE COVERAGE/MEDICARE CARDS

WE MUST HAVE A COPY OF THE RESIDENT'S INSURANCE CARD(S), BOTH THE FRONT AND BACK IN ORDER TO PROCESS PHARMACY CLAIMS THROUGH ANY THIRD PARTY WITHOUT THESE COPIES SHOWING "OTHER PHARMACY" COVERAGE, LACEY'S LTC MUST ASSUME THAT NO COVERAGE EXISTS.

PLEASE BE SURE TO INCLUDE COPIES OF THE INSURANCE CARD(S) WITH THE PATIENT INFORMATION FORMS OR FAX THE INFORMATION TO US SO WE CAN BILL THE APPROPRIATE PARTY(S) FOR PRESCRIPTION PAYMENT.

IT IS THE RESIDENT'S OR THEIR RESPONSIBLE PARTY'S OBLIGATION TO ENSURE WE HAVE THE NECESSARY INFORMATION OF PRESCRIPTION COVERAGE PRIOR TO OUR DISPENSING OF MEDICATIONS.

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

LACEY'S LONG TERM CARE PHARMACY

PHONE: 678-236-0400 FAX: 678-236-0404

APPLICATION FOR SERVICE

COMMUNITY NAME: _____ ROOM # _____

MOVE-IN DATE: _____ RESIDENT HAS MEDICATIONS TO BE REPACKAGED: ☐ YES ☐ NO

RESIDENT'S FULL NAME: _____
(FIRST) (MIDDLE) (LAST)

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ GENDER: M ☐ F ☐

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DRUG ALLERGIES: _____

VACCINE HISTORY:

PNEUMOVAX-23	☐ YES ☐ NO	DATE(S)ADMINISTERED	_____
SHINGRIX	☐ YES ☐ NO	DATE(S) ADMINISTERED	_____
ZOSTAVAX	☐ YES ☐ NO	DATE(S)ADMINISTERED	_____
PREVNAR-13	☐ YES ☐ NO	DATE(S) ADMINISTERED	_____

DOCTOR'S ADDRESS: _____

DOCTOR'S PHONE NUMBER: _____ FAX NUMBER: _____

MONTHLY BILLING PREFERENCE AND AUTHORIZATION

Monthly billing is necessary for medication co-pays and medication charges not covered by your pharmacy insurance plan (e.g., Medicare Part D or another plan). Upon receipt of your billing statement in the first week of each month, you will have 10-15 days to review the charges on your statement and call us if you have any questions about items billed. The amount due will be either submitted to your credit card for payment on the 25th of each month or will be paid by your personal check to Lacey's LTC Pharmacy for receipt in the office no later than the 25th of each month. Please choose either Option A or Option B below for your preferred payment method:

☐ **OPTION A: Pay by Charge/Debit Card (Circle One): VISA MasterCard Discover AmEx**

Card Number: _____

Exp. Date: _____ Security Code: _____

☐ **OPTION B: Pay by Personal Check**

Before filling and delivering any new medication over $150.00/month, the Pharmacy will contact the Responsible Party/Guarantor for approval. Responsible Party/Guarantor's Signature:
_____ Date: _____ **By signing this application, the signing party accepts full responsibility for all pharmacy charges to the resident's account.

LACEY DRUG COMPANY, INC. d/b/a
LACEY'S LONG TERM CARE PHARMACY

4469 LEMON STREET, ACWORTH, GEORGIA 30101

Phone: 678-236-0400 Fax: 678-236-0404

RETAIL CREDIT AGREEMENT/ GUARANTOR'S ACKNOWLEDGEMENT

The undersigned customer ("Guarantor") hereby agrees with the Pharmacy identified above ("Seller") that all purchase of goods and services under Guarantor's charge account with Seller ("Account") shall be subject to:

1. Guarantor agrees to pay in full all purchases charged to the Account and all other amounts, including finance charges due under this agreement. All charges will be billed monthly and are due and payable upon receipt of the billing statement and no later than the 25th of the month. Each billing statement will include all charges and payments and other credits received during the monthly billing period ending on the billing date shown on the billing statement.
2. For Guarantor to avoid a **Finance Charge**, payment for every charge, including a finance charge, must be received by Seller within 20 days after the billing date shown on the billing statement on which the charge was first billed to Guarantor.
3. The balance subject to finance charge ("Finance Balance") shown on a billing statement will consist of charges including finance charges incurred 25 days or more before the billing statement less payments or credits received by Seller by said billing date.
4. On each billing statement on which a Finance Balance appears, a **Finance Charge** will be imposed on the Finance Balance at the periodic rate(s) of 1 1/2% per month (**ANNUAL PERCENTAGE RATE** of 18%) for the Finance Balance subject to a minimum finance charge of $0.50 per month.
5. Seller may at any time amend any of the terms of this agreement upon written notice mailed or delivered to Guarantor in accordance with applicable law and any amendment may apply to balances then outstanding. Seller may limit or terminate Guarantor's right to use the Account without prior notice.
6. If any amount due and payable under this agreement is referred for collection to an attorney or a salaried employee of Seller, Guarantor will be charged and agrees to pay reasonable attorney's fees and costs not exceeding the maximum amount permitted by applicable law.
7. Seller hereby waives any security interest or lien (other than a judgment lien) upon any real property used as the principal residence of Guarantor unless expressly reserved in writing at the time of sale.
8. The laws of the State of Georgia shall govern this agreement.

NOTICE TO THE GUARANTOR

1. **DO NOT SIGN THIS CREDIT AGREEMENT BEFORE YOU READ IT OR IF IT CONTAINS ANY BLANK SPACES.**
2. **YOU ARE ENTITLED TO A COMPLETLEY FILLED IN COPY OF THIS CREDIT AGREEMENT.**
3. **YOU MAY AT ANY TIME PAY YOUR TOTAL INDEBTEDNESS UNDER THIS AGREEMENT.**

_____

(Resident's Name) – PLEASE PRINT FULL NAME OBJ (Facility)

_____

(Guarantor) – PLEASE PRINT FULL NAME

_____

Guarantor's Signature Date

_____

Guarantor's Street Address

_____

Guarantor's City, State and Zip Code

_____

Guarantor's Day Time Phone Number Guarantor's Cell Phone Number

Relationship to Resident: _____

Lacey Drug Company d/b/a

Lacey's Long Term Care Pharmacy

4469 Lemon Street, Acworth, Georgia 30101

Phone: 678-236-0400 Fax: 678-236-0404

REPACKAGING PERSONAL MEDICATIONS

RESIDENT: _____ DATE: _____

FACILITY: _____

There are two circumstances under which a resident's medications acquired from a pharmacy other than Lacey's Long Term Care Pharmacy may be repackaged into the medication dispensing system utilized by this assisted living facility.

1: **UPON ADMISSION TO THE FACILITY**: The resident's initial existing supply of medications will be sent to the pharmacy for repackaging and returned to the facility so the medications can be provided to the patient in an organized and supervised manner. When those medications are used by the resident, all subsequent medications will be provided by Lacey's pursuant to the healthcare provider's orders. Over-the-counter medications will also be provided by Lacey's and packaged in the facility's approved medication administration system.

2: **WHEN THE RESIDENT'S INSURANCE REQUIRES THAT MEDICATIONS ARE PROVIDED ONLY BY A MAIL ORDER DRUG DISTRIBUTOR**, such as the Veterans Administration. Written evidence of mandatory mail order drugs is required. Please forward such evidence to the pharmacy by mail or fax.

Lacey's and the facility are required by law to provide the resident with all medications ordered by medical practitioners. It is the resident's responsibility to deliver to the pharmacy and maintain an adequate supply of medications at the pharmacy for repackaging**. If your supply of medications has run out when it is time for Lacey's to refill the prescription, you hereby authorize Lacey's to fill up to a one-month supply of the medication, bill your insurance company, and bill you for any costs not covered by insurance.**

In addition to packaging medications into the facility's medication administration system, Lacey's is responsible for entering medication orders and order changes on the Medication Administration Record, delivery to the facility on time, and pharmacist review and consultation with the patient, facility, staff, and prescribers.

Medications must be provided to Lacey's in the original pharmacy's containers, and in such a manner that does not require Lacey's to split tablets when the prescribed strength is commercially available. It is a violation of state and federal law for a pharmacy to repackage physician's samples of medications, therefore, samples are prohibited.

A FEE OF $5.00 IS CHARGED FOR EACH REPACKAGED MEDICATION.

ACKNOWLEGMENT

I hereby authorize Lacey's Long-Term Care Pharmacy to repackage medications acquired by me from another pharmacy upon admission, or a mail order drug distributor. I acknowledge that only medications dispensed by a pharmacy licensed in the United States may be repackaged. I assume full and complete responsibility for the quality of the medications and the accuracy of the filling of the prescriptions by another pharmacy pursuant to the prescriber's orders. I hereby indemnify and hold harmless Lacey Drug Company, Inc. and its employees for any damage or harm arising from any activity related to my having acquired medications from a source other than Lacey's.

Resident or Guardian or Responsible Party: Name: _____

Signature: _____ Date: _____

LACEY'S LONG TERM CARE PHARMACY

NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a notable change in our policies, we will change our notice and notify you. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Inspect and obtain a copy of your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health record information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorizations to use or disclose health information except to the extent that action has already been taken.

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your price rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact Larry Braden, 4797 South Main Street, Acworth, Georgia 30101 Phone 770-974-3131.

WRITTEN ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices which describes information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____ _____

Signature of Patient or Legal Representative Witness

_____ _____

Print Patient's Name Date

_____

Facility Name