Hart and Dilatush Pharmacy

ASSIGNMENT OF BENEFITS

Beneficiary Name *(Printed)* _____

Address _____

Phone Number _____ DOB _____

I assign the right and responsibility to Hart and Dilatush Pharmacy to bill on my behalf, and accept payment for Medicare DMEPOS products and services provided to me, the Beneficiary.

I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, which is 20 percent of the allowable or approved charge for a product or service.

I permit Hart and Dilatush Pharmacy to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and Medicare to receive payment from Medicare.

I understand that this form will be maintained and made available to Medicare or its representatives.

_____ _____

Beneficiary/Caregiver Signature Date

_____

Caregiver Printed Name (If Applicable)

Hart and Dilatush Pharmacy
BENEFICIARY INFORMATION *(PLEASE PRINT)*

BENEFICIARY INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address

City | State | Zip

Place of Residence (i.e. Beneficiary Home, Caregiver, LTC, SNF, w/Family) | Residence Phone Number

Emergency Contact Person Name | Emergency Contact's Phone Number

Caregiver's Name | Caregiver's Phone Number

PHYSICIAN INFORMATION

Physician's Name

Office Address

City | State | Zip

Office Phone Number | Date of Last Office Visit

INSURANCE INFORMATION

Medicare Number | Part B Effective Date

Name of Secondary Insurance | Phone

Policy or ID Number | Group Number

Name of Policyholder (if other than Beneficiary)

Beneficiary Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child

Policyholder Date of Birth | Policyholder Social Security Number

Employer's Name

Employer Address

City | State | Zip

I understand that this information is vital for processing Beneficiary prescriptions and will remain confidential.

Beneficiary or Caregiver's Signature | Date

Beneficiary or Caregiver's Printed Name

Hart and Dilatush Pharmacy

DMEPOS PRODUCT(S) SETUP AND DELIVERY

Delivery Date _____ Delivery Time _____

Beneficiary Name _____

Delivery Address _____

Delivery/Setup Completed by _____

DMEPOS *(Product Name & Manufacturer)* _____

DMEPOS Product(s) Delivery Occurred at:
☐ Pharmacy Counter ☐ Residential Care Setting ☐ Beneficiary/Caregiver Home

DMEPOS Product(s) Setup Required *(check all that apply)*:
☐ Sizing ☐ Programming ☐ Battery Insertion ☐ Assembly

☐ Other *(specify)* _____

☐ Setup completed according to Manufacturers'/Prescribing Physician's guidelines

Training and Education Provided *(check all that apply)*:
☐ Beneficiary trained on the proper use, care, maintenance, and storage of Product

☐ Beneficiary aware of all available accessories

☐ Beneficiary alerted to potential risks or hazards associated with Product

☐ Beneficiary understands the setup and the Prescribing Physician's directions

☐ Beneficiary aware of Manufacturer and Pharmacy Customer Service options

☐ Beneficiary asked if they have any questions or concerns *(specify)*

_____

_____

Is follow up needed to answer Beneficiary's questions or concerns? ☐ No ☐ Yes

I acknowledge that I have received the DMEPOS product(s), complete instructions on the use, care and maintenance of, and full documentation for the DMEPOS Product(s) listed above.

_____ _____
Beneficiary/Caregiver Signature Date

_____ _____
Individual Responsible for Delivery/Setup Signature Date

Hart and Dilatush Pharmacy

BENEFICIARY/CAREGIVER QUESTIONS and CONCERNS

Date _____ Time _____

Beneficiary/Caregiver Name _____

Beneficiary/Caregiver Phone _____

Questions/Concerns _____

_____

_____

_____

☐ Resolved Beneficiary's/Caregiver's questions/concerns satisfactorily. Response recorded below. No follow up necessary.

☐ Response requires professional judgment. Forwarded questions/concerns to:

_____ _____
Pharmacy Personnel Name Date

☐ Research required. *(Attach research documentation, if any.)*

☐ Beneficiary/Caregiver informed answer shall be provided by _____
Date/Time

Response provided to Beneficiary/Caregiver as follows:

_____

_____

_____

_____

Answer provided to:

_____ _____
Beneficiary/Caregiver Name (Print) Date/Time of Call

_____
DMEPOS Coordinator Signature

A. Notifier: _____

B. Patient Name: _____ **C. Identification Number:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. **If you have other questions on this notice or Medicare billing, call** 1-800-MEDICARE **(1-800-633-4227/**TTY: **1-877-486-2048).** Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Print Form

NAME _____

MONTH _____

DAY	MORNING READING/ INSULIN UNITS	NOON READING/ INSULIN UNITS	EVENING READING/ INSULIN UNITS	BEDTIME READING/ INSULIN UNITS
1	/	/	/	/
2	/	/	/	/
3	/	/	/	/
4	/	/	/	/
5	/	/	/	/
6	/	/	/	/
7	/	/	/	/
8	/	/	/	/
9	/	/	/	/
10	/	/	/	/
11	/	/	/	/
12	/	/	/	/
13	/	/	/	/
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21	/	/	/	/
22	/	/	/	/
23	/	/	/	/
24	/	/	/	/
25	/	/	/	/
26	/	/	/	/
27	/	/	/	/
28	/	/	/	/
29	/	/	/	/
30	/	/	/	/

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

To ensure the finest care possible, as a Patient receiving Durable Medical Equipment (DME) and our Pharmacy services, you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with DME and Pharmacy services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our Pharmacy, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your DME and Pharmacy services, without fear of discrimination or reprisal
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Pharmacy's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosure of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Pharmacy personnel
- To notify your Physician and the Pharmacy with any potential side effects and/or complications

POLICY & PROCEDURE: *Individual's Rights*

Notice of Privacy Practices

POLICY

The pharmacy will provide individuals a copy of the pharmacy's Notice of Privacy Practices (Notice) upon their first visit to the pharmacy for service on or after April 14, 2003, or when this policy and procedure is implemented (whichever is first). In addition, the pharmacy will post the Notice (and revisions of the Notice) in the pharmacy and make a copy available upon request.

STANDARD

I. INTRODUCTION

Purpose of the Notice of Privacy Practices (Notice): Individuals have a right to an adequate notice of the uses and disclosures of their PHI that may be made by the pharmacy and of the individual's rights and of the pharmacy's legal duties with respect to their PHI.

II. PROVISION OF THE NOTICE

A. Specific requirements for Pharmacy. The pharmacy will follow the criteria listed below to make the Notice available in paper to individuals and the general public.

1. The pharmacy will provide the Notice upon request to any person whether or not that person is a patient of the pharmacy.
2. The pharmacy will provide the Notice at the time of first service, including service delivered electronically, beginning no later than the compliance deadline of April 14, 2003.
3. In an emergency, the pharmacy will provide the Notice as soon as reasonably practicable after the emergency situation.
4. Except in an emergency situation, the pharmacy must make a good faith effort to obtain a written acknowledgement of receipt of the Notice from an individual. If not obtained, the pharmacy will document the efforts made and the reason not obtained.
5. The pharmacy must have copies of the Notice available upon request.
6. The pharmacy must post the Notice in a clear and prominent location where an individual seeking health care will be able to read the notice.

B. Electronic notice. The pharmacy must make an electronic notice available if:

1. If the pharmacy maintains a website that provides information about the pharmacy's customer services or benefits, then the pharmacy must prominently post the Notice on the website.
2. The pharmacy may provide the Notice by email if the individual agrees to receive electronic Notice and such agreement has not been withdrawn. If the pharmacy knows that the email transmission has failed, the pharmacy must provide a paper copy of the Notice to the individual.
3. If the first delivery of the Notice to an individual is electronic, the pharmacy must provide electronic Notice automatically and contemporaneously in response to the individual's first request for service.
4. Upon request, the pharmacy will also provide a paper copy of the Notice to recipients of an electronic Notice.

III. CONTENTS OF THE NOTICE

A. Required Elements. The pharmacy will provide a Notice that is written in plain language and that contains the following required elements:

1. The Notice must contain this statement as a header: "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."
2. Uses and disclosures. The notice must contain:
   a. A description and at least one example of the types of uses and disclosures that the pharmacy is permitted to make for treatment, payment, and health care operations.
   b. A description of each of the other purposes for which a pharmacy is permitted or required to use or disclose PHI without the individual's written consent.
   c. If a use or disclosure is prohibited or materially limited by other laws, the description of such use/disclosure must be reflected in the notice.
   d. The description and examples must include sufficient detail to put the individual on notice of the uses and disclosures

that are permitted or required by the privacy regulations and other applicable laws.

e. A statement that other uses and disclosures may be made only with the individual's written authorization and that the individual may revoke such authorization.

3. Separate statements for certain uses or disclosures. The Notice must include separate statements if the pharmacy plans to engage in any of the following:
   a. The pharmacy may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits or services that may be of interest to the individual.
   b. The pharmacy may contact the individual to raise funds for the pharmacy.
4. Individual Rights. The Notice must contain a statement of the individual's rights with respect to PHI and a brief description of how the individual may exercise these rights, including.
   a. The right to request restrictions on certain uses and disclosures of PHI, including a statement that the pharmacy is not required to agree to a requested restriction.
   b. The right to receive confidential communication of PHI.
   c. The right to inspect and copy PHI.
   d. The right to request an amendment to PHI.
   e. The right to receive an accounting of disclosures of PHI.
   f. The right to receive a paper copy of the Notice.
5. Pharmacy's duties. The Notice must contain:
   a. A statement that the pharmacy is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI.
   b. A statement that the pharmacy is required to abide by the terms of the Notice currently in effect.
   c. A statement that the pharmacy reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all PHI the pharmacy maintains. A statement that describes how the pharmacy will provide individuals with a revised Notice must also be included.
6. Complaints. The Notice will contain a statement that individuals may complain to the pharmacy and to the Secretary of the Department of Health and Human Services if they believe their privacy rights have been violated. This statement will include

how the individual may file a complaint with the pharmacy and that the individual will not be retaliated against for filing a complaint.

7. Contact. The Notice must contain the name or title and telephone number of a person or office to contact for further information.
8. Effective date. The Notice must include the date on which the Notice is first in effect, which may not be earlier than the date on which the Notice is printed or otherwise published.

IV. REVISIONS TO THE NOTICE

A. The right to change the Notice. The pharmacy will state in the Notice that it reserves the right to revise or change its policies and procedures and that the revision may or may not affect all PHI, including previously obtained PHI that the pharmacy maintains.

B. Changes in Law. When there is a change in law that necessitates a revision to the pharmacy's policies and procedures, the pharmacy must promptly document and implement the change to include making revisions to the Notice to reflect the change in law.

C. Implementation. The pharmacy may change its policy at any time; however, implementation cannot begin until the notice has been revised and posted. The date of implementation will be on or after the effective date stated in the Notice.

D. Posting revised Notice. The revised Notice must be posted in a clear and prominent location where an individual seeking health care will be able to read the notice. In addition, the pharmacy will provide, in paper, the revised Notice for all new individuals and for others upon request.

V. DOCUMENTATION

A. The pharmacy will retain copies of the Notice (original and revisions), written acknowledgements of receipt, and documentation of good faith efforts.

B. The pharmacy will retain documentation for six (6) years from the last date in effect.

VI. REFERENCE: Title 45 C.F.R. 164.520.

PROCEDURE

CREATION OF THE PHARMACY'S NOTICE OF PRIVACY PRACTICES

- The Privacy Officer must create a Notice of Privacy Practices which contains all the requirements of section III (Content of the Notice) above.

REVISIONS OF THE NOTICE

Note. The pharmacy must have a statement in the Notice that states that the pharmacy reserves the right to change the notice.

- The pharmacy will document and revise its Notice, including its effective date, upon:
  - Changes in law (HIPAA regulations or state regulations) that necessitate a change in the pharmacy's privacy practice; or
  - Changes in the pharmacy privacy practices.

- The pharmacy's implementation of the revised Notice cannot begin until the Notice has been revised and posted. The date of implementation will be on or after the effective date stated in the Notice.

- The revised Notice will be posted in a clear and prominent location where an individual seeking health care will be able to read the notice. In addition, the pharmacy will provide a paper copy of the revised Notice for all new individuals and for others upon request.

PROVIDING THE PRIVACY NOTICE

- Upon the first visit of the individual on or after April 14, 2003, or when this policy and procedure is implemented (whichever is first), the pharmacy will hand the individual a copy of its most current Notice of Privacy Practices.

- The pharmacy will request the individual to sign the Acknowledgement of Receipt of the Notice of Privacy Practices (*form*). If the individual refuses or is unable to sign, then the pharmacy workforce member will document the good faith effort on the same form.

- [The pharmacy needs to be able to track patients who have signed and who have not signed. This may be a feature that some field in your pharmacy software could perform, or an excel spreadsheet file that will maintain an alphabetical file.]

Note. Once an individual's signature is obtained on the Acknowledgement of Receipt of the Notice of Privacy Practices or good faith effort is documented, the pharmacy will not need to obtain the individual's signature for any subsequent revisions to the Notice.

DOCUMENTATION OF NOTICES

- The pharmacy will retain copies of the Notice (original and revisions), written acknowledgements of receipt, and documentation of good faith efforts according to the pharmacy's Policy and Procedure: Documentation.

FORMS

- SAMPLE Notice of Privacy Practices
- Acknowledgement of Receipt of the Notice of Privacy Practices

Hart and Dilatush Pharmacy

BENEFICIARY SATISFACTION SURVEY
(DMEPOS Products/Services)

In an effort to continuously monitor and maintain the highest degree of customer satisfaction and service you receive from our Pharmacy, please complete this survey and return to the address listed below. We highly value your opinion!

Date _____ Beneficiary Name *(optional)* _____

DMEPOS Product/Service Received _____

Please rate your degree of satisfaction on a scale of 1 – 5.
1 indicating **Complete Dissatisfaction** and **5** indicating **Complete Satisfaction**
(Circle your Score; If Not Applicable, Circle "NA")

1. Customer Service:						
Pharmacist	1	2	3	4	5	NA
Pharmacy Personnel	1	2	3	4	5	NA
DMEPOS Product Trainer	1	2	3	4	5	NA
Delivery Driver	1	2	3	4	5	NA
2. Time Frame for Delivery of Product/Service	1	2	3	4	5	NA
3. Quality of Product/Service Received	1	2	3	4	5	NA
4. Product Ease of Use	1	2	3	4	5	NA
5. Product Set Up	1	2	3	4	5	NA
6. Training Received on Product Use	1	2	3	4	5	NA
7. Training Received on Product Care and Maintenance	1	2	3	4	5	NA
8. Product Safety	1	2	3	4	5	NA

Comments: _____

_____

_____

_____

Please Return Completed Survey to:

[USER INTERVENTION] [Provide Pharmacy's mailing address.]