

# Thank you for choosing CAN Community Health Pharmacy

CAN Community Health Pharmacy is devoted to providing personalized patient care.

Our team of pharmacists are skilled in many disciplines of pharmacy. We are always ready to help!

We are honored to provide you pharmaceutical care and look forward to answering any of your specialized medication questions.

# Welcome to CAN Community Health Pharmacy

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Your Lifetime Health and  
Wellness is Our Commitment



To: Our Valued Patient

CAN Community Health Pharmacies

Clearwater: 2349 Sunset Point Road, Ste 404

Clearwater, FL 33765 Fax: 727-371-1520

Plantation: 4101 NW 3rd Court Ste 9

Plantation, FL 33317 Fax: 954-541-5957

Jacksonville: 4615 Philips Hwy Ste 3

Jacksonville, FL 32207 Fax: 904-240-1597

Arlington, TX: 603 Matlock Centre Circle

Arlington, TX 76015 Fax: 817-717-2174



## About Us

CAN Community Health Pharmacies are located in three Florida locations:

- Jacksonville
- Clearwater
- Plantation

We also have one location in  
-Arlington, Texas

(Please see page 1 for a list of addresses)

Our normal business hours are:  
Monday – Thursday: 8:30am-5:30pm  
Fridays 8:30am-12:30pm (EST)  
Closed Saturday and Sunday.

Here at CCHP we are happy to offer a variety of services, including but not limited to:

- Reimbursement counseling to minimize out-of-pocket costs
- Confidential delivery upon request to your home or doctor's office
- Medication refill reminders
- Side effect management and educational support

## Patient Financial Responsibility

CAN Community Health Pharmacies patients are responsible for any cost insurance does not cover. Payment is expected at time of service. Our goal is to reduce your cost to the lowest possible. For your convenience, we accept cash, checks, money orders, and most major credit cards.

## Receiving Your Medication

We welcome all of our patients to come into the pharmacy and pick up your prescription(s) in person.

Or...you may opt to utilize our delivery service!

- Medication is carefully packaged.
- Medication will be sent to the address of your choice: home, work, doctor's office, a relative's house, etc.  
Your package will arrive within 1-2 business days.
- For packages that may require a signature, an estimated time of arrival can be provided.

## Receiving Medication during an Emergency

We understand that unexpected circumstances may sometimes arise.

Fortunately, we have plans in place to ensure that our patients do not go without medication during an emergency.

## Missed Treatment or Delivery

If you ever miss a treatment dose or do not receive a schedule delivery:

- Call us immediately at 1-844-370-6204 so we can help prevent a gap in therapy.
- If medication is delayed due to weather, shipping, or other emergencies, we can:
  - Arrange an emergency supply
  - Transfer your prescription to nearby pharmacy
  - Expedite Shipping
  - Do NOT stop treatment without consulting with pharmacist or your provider. Our team will guide you on safe steps if a dose is missed.

## Emergency

In the event that the pharmacy must be evacuated or is not reachable due to an emergency, a different site will be chosen where staff will have the ability to access patients' files and assist in getting patients their medications.



## To Reach Our Staff After Hours



## Question, Comment, or Complaint?

We want to hear from you! At CCHP, we strive to always provide our patients with excellent service. Please let us know what you think. We guarantee to quickly assist you with the matter.

- Notify us by telephone, text or email.
- Complaint forms are also available on website.
- Provide feedback by filling out satisfaction surveys. They are sent out to patients at random.
- Surveys are also located on our website.

## Contact Us

CAN Community Health Pharmacies

Email: Tel. 844-370-6204

-jacksonville@cancommunitypharmacies.org  
clearwater@cancommunitypharmacies.org  
ftlauderdale@cancommunitypharmacies.org  
arlington@cancommunitypharmacies.org

Visit us on the Web:

<https://www.cancommunitypharmacies.org/>  
Text us on our Secure Digital RPh Platform. Ask a team member for enrollment information.



## Welcome Packet Acknowledgment Form

Please confirm that you have received the CCHP Welcome Packet by signing below.

Completed forms may be mailed to or faxed:

CAN Community Health Pharmacies:

- Clearwater: 2349 Sunset Point Road, Ste 404 Clearwater, FL 33765 / Fax: 727-371-1520
- Plantation: 4101 NW 3rd Court Ste 9 Plantation, FL 33317 / Fax: 954-541-5957
- Jacksonville: 4615 Philips Hwy Ste 3 Jacksonville, FL 32207 / Fax: 904-240-1597
- Arlington, TX: 603 Matlock Centre Circle Arlington, TX 76015 / Fax: 817-717-2174

- ✓ I have received your Welcome Packet, which includes Hours of Operations and Scope of Services provided; Patient Bill of Rights and Responsibilities, Privacy Notice, Patient Financial Responsibility, Emergency Preparedness Education, and Informed Consent form. I have read through it carefully, and fully understand; therefore, I have signed it and sent it back to you as requested.
- ✓ I have opted to use and authorize consent for CAN Community Health Pharmacies to fill my prescriptions and have them delivered\* to me when necessary for safety and/or convenience and agree to sign and return any accompanying Pharmacy Delivery Record, as CCHP is required to obtain a verified signature of receipt for each filled prescription.

☐ Only check this box if you do NOT wish to have your medication(s) delivered to you and will be picking them up instead.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **PLEASE PROVIDE EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_

Phone # \_\_\_\_\_ Home/Alternate # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Thank you for choosing CAN Community Health Pharmacy!



|                                                                                                                                   |                                                                                                                               |                                                                                                                                       |                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <b><u>Location:</u></b><br>CAN Community<br>Health Pharmacy<br>Jacksonville                                                       | <b><u>Location:</u></b><br>CAN Community<br>Health Pharmacy<br>Clearwater                                                     | <b><u>Location:</u></b><br>CAN Community<br>Health Pharmacy<br>Ft. Lauderdale                                                         | <b><u>Location:</u></b><br>CAN Community<br>Health Pharmacy<br>Arlington                                                    |
| <b><u>Email:</u></b><br><a href="mailto:jacksonville@cancommunitypharmacies.org">jacksonville@cancommunity<br/>pharmacies.org</a> | <b><u>Email:</u></b><br><a href="mailto:clearwater@cancommunitypharmacies.org">clearwater@cancommunity<br/>pharmacies.org</a> | <b><u>Email:</u></b><br><a href="mailto:fortlauderdale@cancommunitypharmacies.org">fortlauderdale@cancommunity<br/>pharmacies.org</a> | <b><u>Email:</u></b><br><a href="mailto:arlington@cancommunitypharmacies.org">arlington@cancommunity<br/>pharmacies.org</a> |
| <b><u>Fax:</u></b><br>904-240-1597                                                                                                | <b><u>Fax:</u></b><br>727-371-1520                                                                                            | <b><u>Fax:</u></b><br>954-541-5957                                                                                                    | <b><u>Fax:</u></b><br>817-717-2174                                                                                          |

#### **AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

In accordance with the Federal Government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), for our pharmacists or staff to be able to discuss your conditions and/or medications with your family members or other individuals that you designate, we must obtain your signed authorization.

I authorize CAN COMMUNITY HEALTH PHARMACY to verbally release any or all information concerning my medical/prescription care to the following individuals:

| <b>Last Name</b> | <b>First Name</b> | <b>Relationship</b> | <b>Phone #</b> |
|------------------|-------------------|---------------------|----------------|
| 1.               |                   |                     |                |
| 2.               |                   |                     |                |
| 3.               |                   |                     |                |

\_\_\_\_\_ I do not authorize CAN Community Health Pharmacy to release any of my information with any individuals.

I understand that I can cancel this consent at any time by writing to CAN Community Health Pharmacy. This authorization will be in effect until I cancel in writing.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### CUSTOMER CREDIT CARD AUTHORIZATION FORM

CCHP accepts most major credit cards for payment. Please fill out this form to pay for co-payments and/or other fees using a credit card. CCHP will contact you if there is a copay or other fee.

**Please enter the information of the patient that this payment will be made for below:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Billing Address \_\_\_\_\_

Phone# \_\_\_\_\_ Email \_\_\_\_\_

☐

**OPT OUT of Credit Card Authorization, call for payment information**

|                                                                         |                                  |                                                                            |                               |                                   |
|-------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------|-------------------------------|-----------------------------------|
| Account Type:                                                           | <input type="checkbox"/> Visa    | <input type="checkbox"/> MasterCard                                        | <input type="checkbox"/> AmEx | <input type="checkbox"/> Discover |
| (Select all that apply)                                                 | <input type="checkbox"/> FSA/HSA | <input type="checkbox"/> Call for authorization if charge exceeds \$ _____ |                               |                                   |
| Name of Cardholder                                                      | _____                            |                                                                            |                               |                                   |
| Card Number                                                             | _____                            |                                                                            |                               |                                   |
| Expiration Date                                                         | _____                            |                                                                            |                               |                                   |
| CVV Number                                                              | _____                            | Zip Code                                                                   | _____                         |                                   |
| (3 digit number on back of Visa/MC, or 4 digit number on front of AmEx) |                                  |                                                                            |                               |                                   |

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

I authorize the above named business to charge the credit card indicated on this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated on this form.



# Notice of Privacy Practices

**Your Information. Your Rights. Our Responsibilities.**  
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.**  
Este folleto está disponible en español. Por favor, consulte la recepción.

## Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Get an electronic or paper copy of your medical record</b> | You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br><br>We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.                                                                                                                                                                            |
| <b>Request confidential communications</b>                    | You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br><br>We will say “yes” to all reasonable requests of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.                                                                                                                                                                                           |
| <b>Get a list of those with whom we’ve shared information</b> | You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.<br><br>We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| <b>Choose someone to act for you</b>                          | If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br><br>We will make sure the person has this authority and can act for you before we take any action.                                                                                                                                                                                                      |

## Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

|                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>In these cases you have both the right and choice to tell us too:</b>                      | Share information with your family, close friends, or others involved in your care<br>Share information in a disaster relief situation<br>Include your information in a hospital directory<br><br><b>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</b> |
| <b>In these cases, we never share your information unless you give us written permission:</b> | Marketing purposes<br>Sale of your information<br>Most sharing of psychotherapy notes<br><br><b>The only way we may share this information is if you give us written permission.</b>                                                                                                                                                                                                                                                                                                           |
| <b>In the case of fundraising:</b>                                                            | We may contact you for fundraising efforts, but you can tell us not to contact you again                                                                                                                                                                                                                                                                                                                                                                                                       |

## Our Responsibilities

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>WE will protect your information:</b>    | We are required by law to maintain the privacy and security of your protected health information.<br><br>We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.<br><br>We must follow the duties and privacy practices described in this notice and give you a copy of it.<br><br>We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.<br><br>For more information on see: <a href="http://www.hhs.gov/hipaa">www.hhs.gov/hipaa</a> . |
| <b>Changes to the Terms of This Notice:</b> | We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.<br><br>This Notice of Privacy Practices applies to the following organizations.                                                                                                                                                                                                                                                                                                                                                                                                  |

|                         |                                                                                                                                                                                                                                                                                                                        |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>For Information:</b> | <div>CAN COMMUNITY HEALTH, INC.<br/>CANCOMMUNITYHEALTH.ORG<br/>ADAM CARROLL, CHC, CHPC<br/>DIRECTOR OF COMPLIANCE</div> <div>EMAIL: <a href="mailto:COMPLIANCE@CANCOMMUNITYHEALTH.ORG">COMPLIANCE@CANCOMMUNITYHEALTH.ORG</a><br/>TEL: (941) 300-4440<br/>ADDRESS: 2105 NORTH NEBRASKA AVENUE<br/>TAMPA, FL 33602</div> |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ask us to correct your medical record</b>                 | You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br><br>We may say “no” to your request, but we’ll tell you why in writing within 60 days.                                                                                                                                                                                                                                                                                                              |
| <b>Ask us to limit what we use or share</b>                  | You can ask us not to use or share certain health information for treatment, payment, or our operations.<br><br>We are not required to agree to your request, and we may say “no” if it would affect your care.<br><br>If you pay for a service or health care item out- of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<br><br>We will say “yes” unless a law requires us to share.                                                     |
| <b>Get a copy of this privacy notice</b>                     | You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.                                                                                                                                                                                                                                                                                                                                                          |
| <b>File a complaint if you feel your rights are violated</b> | You can file a complaint if you feel we have violated your rights by contacting us using the information on the back page.<br><br>You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a> . We will not retaliate against you for filing a complaint. |

## Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

|                                                                                  |                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Treat you</b>                                                                 | We can use your health information and share it with other professionals who are treating you.<br><br>Example: A doctor treating you for an injury asks another doctor about your overall health condition.                                                                                                                                                  |
| <b>To Run our organization</b>                                                   | We can use and share your health information to run our practice, improve your care, and contact you when necessary.<br><br>Example: We use health information about you to manage your treatment and services.                                                                                                                                              |
| <b>To bill for services</b>                                                      | We can use and share your health information to bill and get payment from health plans or other entities.<br><br>Example: We give information about you to your health insurance plan so it will pay for your services.                                                                                                                                      |
| <b>How else can we use or share your health information?</b>                     | We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.<br><br>For more information see: <a href="http://www.hhs.gov/hipaa">www.hhs.gov/hipaa</a> . |
| <b>To help with public health and safety issues</b>                              | We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone’s health or safety.                                                      |
| <b>To do research</b>                                                            | We can use or share your information for health research.                                                                                                                                                                                                                                                                                                    |
| <b>Comply with the law</b>                                                       | We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.                                                                                                                                                        |
| <b>To respond to organ and tissue donation requests</b>                          | We can share health information about you with organ procurement organizations.                                                                                                                                                                                                                                                                              |
| <b>To work with a medical examiner or funeral director</b>                       | We can share health information with a coroner, medical examiner, or funeral director when an individual dies.                                                                                                                                                                                                                                               |
| <b>For workers’ compensation, law enforcement, and other government requests</b> | We can use or share health information about you: For workers’ compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services.                            |
| <b>To respond to lawsuits and legal actions</b>                                  | We can share health information about you in response to a court or administrative order, or in response to a subpoena.                                                                                                                                                                                                                                      |



## PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

### Patients have the right to:

1. Be fully informed verbally and/or in writing in advance about services/care to be provided.
2. Provided any charges that may occur prior to treatment or receiving medication.
3. Be treated with dignity, courtesy and respect as a unique individual, without discrimination.
4. Be able to identify company employees through name and job title (Name badge, Job title) and to speak with a pharmacist if requested.
5. Choose a healthcare and pharmacy provider.
6. Receive information about the scope of care/services that are provided by CCHP as well as any limitations to the company's care/service capabilities.
7. Receive upon request evidence-based practice information for clinical decisions (manufacturer package insert, published practice guidelines, peer-reviewed journals, etc.) including the level of evidence or consensus describing the process for intervention in instances where there is no evidence-based research, conflicting evidence, or no level of evidence.
8. Receive in advance of services being provided, complete verbal or written explanations of expected payments from Medicare or any other third-party payer, charges for which you may be responsible, and explanation of all forms you are requested to sign.
9. Receive quality medications and services that meet or exceed professional and industry standards regardless of race, religion, political belief, sex, social or economic status, age, disease process, DNR status or disability in accordance with physician orders.
10. Receive medications and services from qualified personnel and receive instructions and education on safely handling and taking medications.
11. Receive information regarding your order status. Patients or caregivers can call (844) 370-6204 and speak with a CCHP pharmacy employee.
12. Receive prompt response on all inquiries.
13. Be informed of rights and responsibilities during the whole treatment process.
14. Confidentiality and privacy of all the information contained in your records and of Protected Health Information (except as otherwise provided for by law or third-party payer contracts).
15. If desired, to be referred to other health care providers within an external health care system (ex. Dietician, mental health services, etc.). Patients may also be referred to back to their own prescriber for follow up.
16. Receive information about when and to whom your personal health information was disclosed, as permitted under applicable law and as specified in the company's policies and procedures.
17. Express dissatisfaction/concerns/complaints for lack of respect, treatment or service, and to suggest changes in policy, staff or services without discrimination, restraint, reprisal, coercion, or unreasonable interruption of services. Patients or caregivers can call (844) 370-6204 and ask to speak with a pharmacist, supervisor, or pharmacy director.
18. Have concerns/complaints/dissatisfaction about services be investigated properly.
19. Be offered assistance with any eligible internal programs that help with patient management services, manufacturer copay and patient assistance programs, health plan programs (tobacco cessation programs, disease management, suicide prevention/behavioral health programs).
20. Be advised of pharmacy number, (844) 370-6204 after hours as well as normal business hours of Monday-Thursday 8am-5:30pm, Friday 8am-12:30pm, Saturday/Sunday-Closed (EST).
21. Be advised of any change in the plan of service before the change is made.
22. Participate in the development and periodic revision of the plan of care/service.
23. Receive information in a manner, format and/or language that you understand.
24. Have family members, as appropriate and as allowed by law, with your permission or the permission of your surrogate decision maker, involved in care, treatment, and/or service decisions.
25. Be fully informed of your responsibilities.
26. To be automatically enrolled in CCHP's Patient Management Program as a patient of CCHP at no additional cost. You have the right to opt out, decline participation, revoke consent or disenrollment in any CCHP services at any point in time. To learn more about the Patient Management Program, please call CCHP and ask for a clinical pharmacist.
27. To know the philosophy and characteristics of the Patient Management Program, have personal health information shared with the patient management program only in accordance with state and federal law, speak to a health professional, receive information about the patient management program, and receive administrative information regarding changes in (or termination of) the patient management program.
28. To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property.
29. The patient has the right to express grievances, make suggestions to the organization and complain to the Florida Board of Pharmacy Telephone: **(850) 245-4339** Mailing Address: **Consumer Services, 4052 Bald Cypress Way, Bin C75, Tallahassee, Florida 32399-3275**. For information on how to submit a complaint or grievance to another state board of pharmacy, please go to <https://nabp.pharmacy/about/boards-of-pharmacy> to find your states contact info. You can also submit complaints and grievances to the Accreditation Commission for Health Care, Inc. "ACHC" at **855-937-2242**.

### Patients have the Responsibility to:

1. Adhere to the plan of treatment or service established by your physician and to notify him/her of your participation in CCHP's Patient Management Program.
2. Notify CCHP if you are hospitalized.
3. Inform your physician you are a patient of CCHP and are enrolled in our Patient Management Program.
4. Participate in the development of an effective plan of care/treatment/services. Pharmacists will discuss with you any concerns or questions you have regarding your medication. Issues discussed include disease overview, medication, dose, when to take medication, interactions, side effects, and anything else appropriate for your specific needs.
5. Provide, to the best of your knowledge, accurate and complete medical and personal information necessary to plan and provide care/services.
6. Ask questions about your care, treatment and/or services.
7. Have clarified any instructions provided by company representatives.
8. Communicate any information, concerns and/or questions related to perceived risks in your services, and unexpected changes in your condition.
9. Be available to receive medication deliveries and coordinate with CCHP during the times you will be unavailable.
10. Treat pharmacy personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
11. Provide a safe environment for the organization's representatives to provide services.
12. Use medications according to instructions provided, for the purpose it was prescribed, and only for/on the individual to whom it was prescribed.
13. Communicate any concerns on ability to follow instructions provided.
14. Promptly settle unpaid balances except where contrary to federal or state law.
15. Notify pharmacy of change in prescription or insurance coverage.
16. Notify pharmacy immediately of address or telephone changes, temporary or permanent.
17. As part of the Patient Management Program, you have the Responsibilities to submit forms that are necessary to participate in the program, to the extent required by law, and give accurate clinical and contact information and to notify the patient management program of changes in this information.

UNLESS OTHERWISE INDICATED, all materials on these pages are created by CCHP. All rights reserved. No part of these pages, either text or image, may be used for any purpose other than personal use. Therefore, reproduction, modification, storage in a retrieval system or retransmission, in any form or by any means, electronic, mechanical or otherwise, for reasons other than personal use, is strictly prohibited without prior written permission

**By signing below, I attest that I have received a copy of CAN Community Health  
Pharmacies Notice of Privacy Practices and Patient Bill of Rights and  
Responsibilities**

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

# YOUR HEALTH INFORMATION, YOUR RIGHTS

GET IT. CHECK IT. USE IT.



## DID YOU KNOW?



8 in 10 individuals who have viewed their medical record online considered the information useful.<sup>1</sup>



27% of individuals were unaware or didn't believe they had a right to an electronic copy of their medical record.<sup>1</sup>



41% of Americans have never even seen their health information.<sup>2</sup>



HIPAA (Health Insurance Portability and Accountability Act of 1996) gives us the right to access our health information.

## KNOW YOUR RIGHTS

Hannah is a 50-year-old woman recently diagnosed with Type 2 Diabetes.

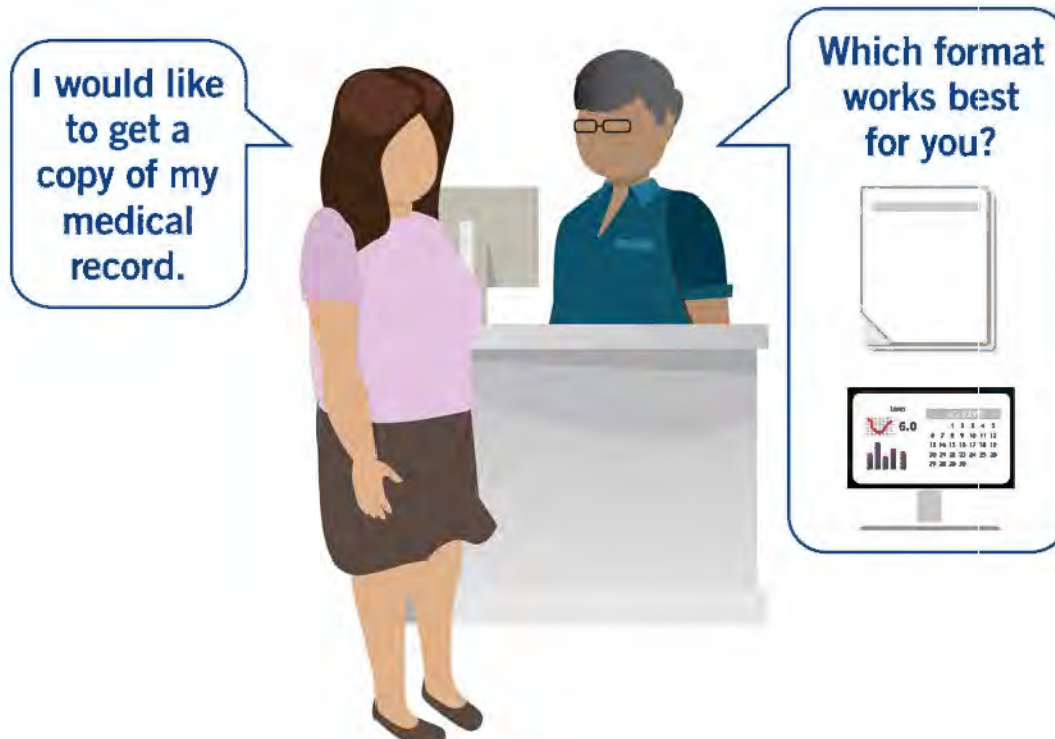


Like all individuals, Hannah has a right to see and get a copy of her health information.



*You cannot be refused access to your health information because you haven't paid your health care bill.*

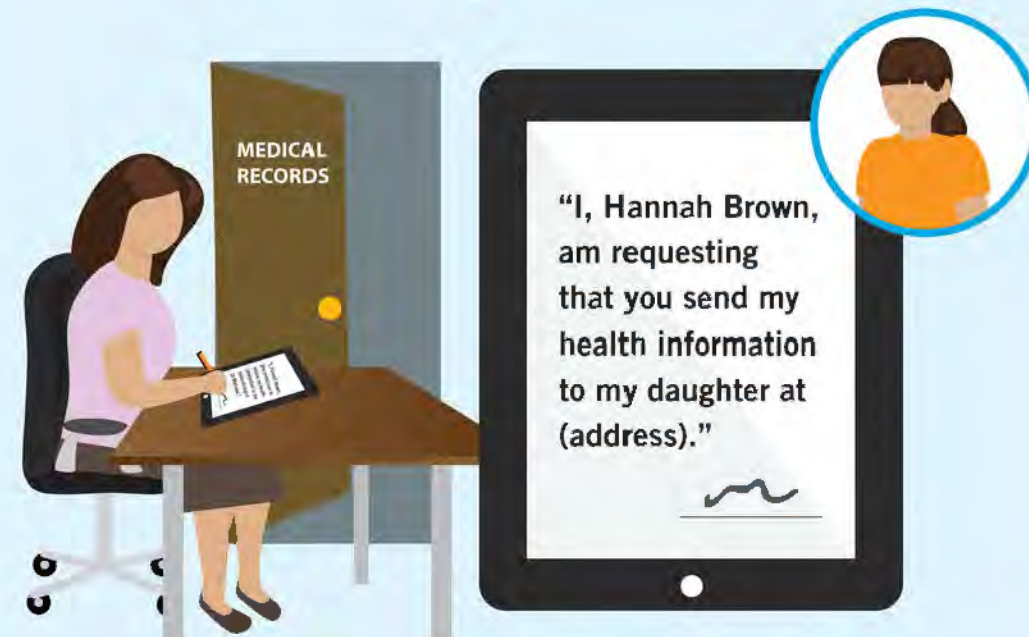
With a copy of your medical record you can become more informed about your health.



## SEND YOUR HEALTH INFORMATION TO A THIRD PARTY



You hold the key to your health information and can send or have it sent to anyone you want. Only send your health information to someone you trust.



Your provider is no longer responsible for the security of your health information after it is sent to a third party.



Be careful when sending your health information to a mobile application or other third party.

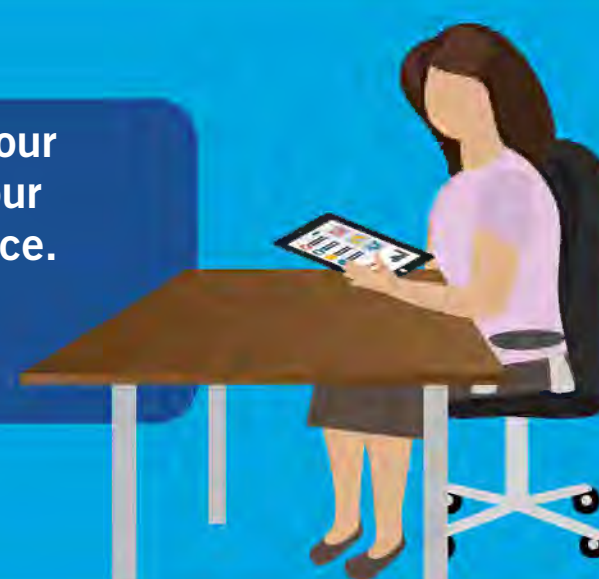
## PROTECT YOUR HEALTH INFORMATION



Once you have a copy of your health information, it is important to keep it protected.

Passwords can protect your health information on your computer or mobile device.

\*\*\*\*\*



Sources: 1. [https://www.healthit.gov/sites/default/files/briefs/oncatabrief30\\_accesstrends\\_.pdf](https://www.healthit.gov/sites/default/files/briefs/oncatabrief30_accesstrends_.pdf)

2. <https://www.healthit.gov/buzz-blog/consumer/making-patient-access-health-information-reality/>

## LEARN MORE ABOUT YOUR RIGHTS



[WWW.HEALTHIT.GOV/ACCESS](http://WWW.HEALTHIT.GOV/ACCESS)  
[www.hhs.gov/hipaa/for-professionals/privacy/guidance/access](http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access)





## PATIENT CONCERNS / COMPLAINT FORM

CCHP strives to guarantee excellent service that matches our values. You have the right to voice your concerns or complaints about your service at any time. If you are unhappy with our service, have concerns about safety, or unhappy with quality of care, we would like you to contact our management team.

### How to make a complaint:

- You may complete this form and email to [forms@cancommunitypharmacies.org](mailto:forms@cancommunitypharmacies.org).
- Call toll free 844- 370-6204 ask for Pharmacist or to speak with a supervisor.
- Visit our website at <https://www.cancommunitypharmacies.org> to submit your concerns.
- Submit to the:
  - Florida Board of Pharmacy
    - Telephone: (850) 245-4339 Mailing Address: Consumer Services, 4052 Bald Cypress Way, Bin C75, Tallahassee, Florida 32399-3275.
  - Georgia Board of Pharmacy
    - Telephone: (404) 651-8000 Address: 2 M.L.K. Jr Dr SE, Atlanta, GA 30334
  - Texas Board of Pharmacy
    - Telephone: (512)305-8000 Address: 333 Guadalupe St #3, Austin, TX 78701
- For information on how to submit a complaint or grievance to another state board of pharmacy, please go to <https://nabp.pharmacy/about/boards-of-pharmacy> to find your states contact info.
- Submit complaints and grievances to the Accreditation Commission for Health Care, Inc. "ACHC" at 855-937-2242.

CCHP will contact you within 3 calendar days after receiving your concern. You will receive a telephone and/or written response from our management.

Thank you in advance for bringing your concern to our attention. We will continue to learn from our patients and work to improve the quality of our services.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Description of the problem/concern/complaint (include dates, times and names, if possible):

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Completed by (signature): \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient (if applicable): \_\_\_\_\_

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### (FOR OFFICE USE ONLY)

Patient's Address: \_\_\_\_\_

Date Received: \_\_\_\_\_ by: \_\_\_\_\_

Follow-up by letter completed by: \_\_\_\_\_

Enrollee name: \_\_\_\_\_(optional)

Drug and prescription number: \_\_\_\_\_(optional)

## **Medicare Drug Coverage and Your Rights**

**You have the right to ask for a coverage determination** from your Medicare drug plan to provide or pay for a drug you think should be covered, provided, or continued. You also have the right to ask for a special type of coverage determination called an **“exception”** if you:

- Need a drug that’s not on your plan’s list of covered drugs
- Believe a coverage rule (like prior authorization or a quantity limit) shouldn’t apply to you for medical reasons
- Need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price

### **How to ask for a coverage determination**

To ask for a coverage determination, you or your prescriber can call your Medicare drug plan’s toll-free phone number on the back of your plan membership card, or go to your plan’s website. You can ask for an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision.

Be ready to tell your Medicare drug plan:

- The name of the prescription drug, including dose and strength (if known)
- The name of the pharmacy that tried to fill the prescription
- The date you tried to fill the prescription
- If you ask for an exception, your prescriber will need to explain why you need the off-formulary or non-preferred drug, or why a coverage rule shouldn’t apply to you

Your Medicare drug plan will send you a written decision. If coverage isn’t approved and you disagree with this decision, you have the right to appeal. The plan’s notice will explain why coverage was denied and how to ask for an appeal.

### **Get help and more information**

Look at your plan materials or call 1-800-MEDICARE (1-800-633-4227) for more information about how to ask for a coverage determination. TTY users can call 1-877-486-2048. For help contacting your plan, call 1-800-MEDICARE.

To get this form in an accessible format (like large print, Braille, or audio) contact your Medicare drug plan. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

**PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. This information collection is used to provide notice to enrollees about how to contact their Part D plan to request a coverage determination. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required under § 423.562(a)(3) and an associated regulatory provision at § 423.128(b)(7)(iii). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Disaster can strike at any time and without warning. By preparing in advance, you can help make sure you'll have the medications you need and one less thing to worry about in an emergency.

## Some Simple Tips

- Don't wait until you're almost out of medication to order more. Be sure to keep an adequate supply on hand. If a disaster forces you to leave your home, you'll need to take at least three days' worth of medication and supplies with you, and more if local authorities advise.
- Keep all your medications together so you can grab them quickly and take them with you if you need to evacuate.
- Make a list of your medications, and keep it in your wallet, along with your prescription drug ID card. This brochure includes a handy medication information card that you can use to record such information and other important facts that you may need to get your medication.
- Consider discussing your medication disaster plan with your doctor, especially if the medication you take has special shipping requirements or requires electronic equipment (such as a nebulizer) for administration.
- If you have a child who takes prescription medication on a regular basis, it's a good idea to speak with your child's daycare center or school about their plan for dealing with your child's medication and medication needs in an emergency.

## Additional Information

For more information, visit the following websites:

American Red Cross  
[www.redcross.org](http://www.redcross.org)

Florida Division of Emergency Management  
[www.floridadisaster.org](http://www.floridadisaster.org)

Federal Emergency Management Agency [www.fema.gov](http://www.fema.gov)

My Doctor:

Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_

My participating retail pharmacy

Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_

My local post office

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

CAN Community Health Pharmacies  
Toll-Free 1-844-370-6204



## Creating a Medication Disaster Plan



## Simple Tips for Planning Ahead

## How CCHP Help

If you find yourself without your prescription medications during a disaster, we can help get them to you as soon as possible.

Call CAN Community Health Pharmacies right away at 844-370-6204

### Delivery

During an emergency situation, including natural disasters, be sure to keep us informed of any changes in your location so that we may arrange for the shipping of your medications to an alternate address. Please remember to plan ahead, as these situations can make for delayed shipping and delivery times.

### Pick-up

Your medications may also be made available for pick-up at our retail location. During an emergency or natural disaster, if shipping and delivery are not available and you are not able to pick up your medications, we can always transfer your prescription(s) to a pharmacy nearest to you for your convenience.

Contact Us  
CAN Community Health Pharmacies  
Email: Tel. 844-370-6204  
-jacksonville@cancommunitypharmacies.org  
clearwater@cancommunitypharmacies.org  
ftlauderdale@cancommunitypharmacies.org  
arlington@cancommunitypharmacies.org  
Visit us on the Web:  
<https://www.cancommunitypharmacies.org/>

## Medication Information Card

Fill out the card below and keep it with your prescription drug ID card. That way, you'll have the information you need to get your medications during an emergency.

If other members of your household take medications on a regular basis, make copies of the card to use for their information, too.

**Planning ahead for your medications means one less thing to worry about in an emergency.**



### Medication I Take

List the drug name, strength (for example, 500 mg), dosage form (tablet, capsule or liquid) and directions for use for each medication you take.

Drug name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage form: \_\_\_\_\_ Directions: \_\_\_\_\_

Drug name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage form: \_\_\_\_\_ Directions: \_\_\_\_\_

Drug name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage form: \_\_\_\_\_ Directions: \_\_\_\_\_

## Special Considerations

By developing an emergency plan, you'll be one step ahead in a disaster situation. Here are a few other things you can prepare for ahead of time:

### When medication requires refrigeration

Keep a cooler on hand that you can fill with ice so you can keep your medication at the proper temperature if you need to be away from your home.

### When medication requires electronic equipment for administration

Be prepared to take action. If the power goes out, you'll need to take at least three days' worth of medication and supplies with you (more if local authorities advise) to the closest hospital or shelter.

### When you must leave your home for a few days

Stock a disaster supply kit with any nonprescription medications you may need (for example, aspirin or other pain relievers, cold medicine and antacids). You may also want to keep a copy of your medication information card in this kit.

**Help is available anytime, day or night.**

**Just call 1-844-370-6204!**

I need to get rid  
of this medication.

# Drug Disposal Options

Do you have medicine you want to get rid of?

Do you have a drug take-back  
option readily available?

Check the [DEA website](#), as well as your local  
drugstore and police station for possible options.

**NO**

**YES**

Is it on the [FDA flush list](#)?

**NO**

Follow the FDA  
[instructions for  
disposing of  
medicine  
in the  
household  
trash.](#)

**YES**

[Immediately  
flush your  
medicine in  
the toilet.](#)

Scratch out all  
personal info  
on the bottle  
and recycle/  
throw it away.

Take your  
medicine  
to a drug  
take-back  
location.

Do this  
promptly for  
[FDA flush list](#)  
drugs!

# Washing Your Hands

You can help yourself and your loved ones stay healthy by washing your hands often, especially during these key times when you are likely to get and spread germs:

- Before, during, and after preparing food.
- Before eating food.
- Before and after caring for someone at home who is sick with vomiting or diarrhea.
- Before and after treating a cut or wound.
- After using the toilet.
- After changing diapers or cleaning up a child who has used the toilet.
- After blowing your nose, coughing, or sneezing.
- After touching an animal, animal feed, or animal waste.
- After handling pet food or pet treats.
- After touching garbage.

### Follow Five Steps to Wash Your Hands the Right Way

Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities and hospitals.

Follow these five steps every time:

1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. Scrub your hands for at least 20 seconds. Do you need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. Rinse your hands well under clean, running water.
5. Dry your hands using a clean towel or air dry them.

### Use Hand Sanitizer When You Can't Use Soap and Water

Washing hands with soap and water is the best way to get rid of germs in most situations. If soap and water are not readily available, you can use an alcohol-based hand sanitizer that contains at least 60% alcohol. You can tell if the sanitizer contains at least 60% alcohol by looking at the product label.

Sanitizers can quickly reduce the number of germs on hands in many situations. However,

- Sanitizers do not get rid of all types of germs.
- Hand sanitizers may not be as effective when hands are visibly dirty or greasy.
- Hand sanitizers might not remove harmful chemicals from hands like pesticides and heavy metals.

How to use hand sanitizer:

- Apply the gel product to the palm of one hand (read the label to learn the correct amount).
- Rub your hands together.
- Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds.

# Home Safety Information

Here are some helpful guidelines to help you keep a careful eye on your home and maintain safe habits. The safe way is always the right way to do things. Shortcuts may hurt. Correct unsafe conditions before they cause an accident. Take responsibility. Keep your home safe. Keep emergency phone numbers handy.

## Medication

- If children are in the home, store medications and poisons in childproof containers and out of reach.
- All medication should be labeled clearly and left in original containers.
- Do not give or take medication that were prescribed to other people.
- When taking or giving medication, read the label and measure doses carefully.
- Know the side effects of the medication you are taking.
- Do not throw away outdated medication by pouring down a sink or flushing down the toilet.

## Slips and/or Falls

Slip and falls are the most common and often the most serious accidents in the home. Here are some things you can do to prevent them in your home.

- Arrange furniture to avoid an obstacle course.
- Install handrails on all stairs, showers, bathtubs, and toilets.
- Keep stairs clear and well lit.
- Place rubber mats or grids in showers and bathtubs.
- Use bath benches or shower chairs if you have muscle weakness, shortness of breath or dizziness.
- Wipe up all spilled water, oil or grease immediately.
- Pick up and keep surprises out from under your feet, including electrical cords and rugs.
- Keep drawers and cabinets closed.
- Install good lighting.

## Mobility Items

When using mobility items to get around such as canes, walkers, wheelchairs, or crutches you should use extra care to prevent slips and falls.

- Use extreme care to avoid using walkers, canes or crutches on slippery or wet surfaces.
- Always put the wheelchairs or seated walkers in the lock position when standing up or before sitting down.
- Wear shoes when using these items and try to avoid obstacles in your path and soft and uneven surfaces.

## Lifting

If it is too big, too heavy or too awkward to move alone - GET HELP. Here are some things you can do to prevent low back pain or injury:

- Stand close to the load with your feet apart for good balance.
- Bend your knees and "straddle" the load.
- Keep your back as straight as possible while you lift and carry the load.
- Avoid twisting your body when carrying a load.
- Plan ahead - clear your way.

## Electrical Accidents

Watch for early warning signs; overheating, a burning smell or sparks. Unplug the appliance and get it checked right away.

Here are some things you can do to prevent electrical accidents:

- Keep cords and electrical appliances away from any water or leaks.
- Do not plug cords under rugs, through doorways or near heaters. Check cords for damage before use.
- Extension cords must have a large enough wire for larger appliances.
- If you have a broken plug outlet or wire, get it fixed immediately.
- Use a grounded 3-wire plug to prevent shock in case of electrical fault.
- Do not overload outlets with too many plugs.
- Use three-prong adapters when necessary.

## Smell Gas?

- Open windows and doors immediately.
- Shut off appliance(s) involved. You may be able to refer to the front of your telephone book for instructions regarding turning off the gas to your home.
- Do not use matches or turn on electrical switches.
- Do not use the telephone - dialing may create electrical sparks.
- Do not light candles.
- Call your Gas Company from a neighbor's home.
- If your gas company offers free annual inspections, take advantage of them.

## Fire

Pre-plan and practice your fire escape. Look for a plan with at least two ways out of your home. If your fire exit is through a window, make sure it opens easily. If you are in an apartment, know where the exit stairs are located. Do not use the elevator in a fire emergency. You may notify the fire department ahead of time if you have a disability or special needs. Here are some steps to prevent fires:

- Install smoke detectors. They are your best early warning. Test frequently and change the battery every year (or as needed).
- If there is oxygen in use, place a "No Smoking" sign in plain view of all people entering the home.
- Throw away old newspapers, magazines and boxes.
- Empty waste baskets and trashcans regularly.
- Do not allow ashtrays or toss matches into wastebaskets unless you know they are out. Wet down first or dump into toilet.
- Have your chimney and fireplace checked frequently. Look for and repair cracks and loose mortar. Keep paper, wood and rugs away from areas where sparks could hit them.
- Be careful when using space heaters.
- Follow instructions when using a heating pad to avoid serious burns.
- Check your furnace and pipes regularly. If nearby walls or ceilings feel hot, add insulation.
- Keep a fire extinguisher in your home and know how to use it.

## If you have a fire or suspect fire:

1. Take immediate action per plan - escape is your top priority.
2. Get help on the way - with no delay. CALL 9-1-1.
3. If your fire escape is cut off, close the door and seal the cracks to hold back smoke. Signal help from the window.