BHS Pharmacy
Your Prescription for Caring

PRESCRIPTION PAYMENT PLAN AGREEMENT

RESIDENT INFORMATION

(Please Print)

Name _____Facility _____

Birth Date ____/____/____ S.S.N. _____-_____-_____

Insurance Plan _____ (Please attach a copy of insurance card, both front and back)

Nearest Relative _____ Relationship _____

Address _____Phone# (_____) _____

PAYMENT INFORMATION

Responsible Party Name _____

Address _____ Phone# (_____) _____

City_____ State _____Zip _____ Email _____

I hereby authorize payment for charges to the BHS Pharmacy account using the following payment method:
(Check One)

_____ **Credit Card/Debit Card**

CC/DC # _____ Exp Date _____

Credit card and debit cards will be preauthorized in the amount of the expected monthly account charges.

_____ **Automatic Bank Withdrawal**

Save time, stamps, and envelopes by using Automatic Withdrawal. (To use this method of payment attach a blank check with the word VOID written across the face of the check).

_____ **Prepaid Deposit** Amount of Deposit $ _____

Prepaid deposits must be greater than the expected monthly account charges. All account charges must be paid in full within 30 days of the statement date to avoid late charges.

I also agree to the following BHS Pharmacy account terms and conditions:

A statement will be issued by the seventh day of each calendar month to the Responsible Party via email, fax, or USPS. The amount of the current monthly account balance is immediately due on the statement date regardless of any discrepancies or disputes and will be paid by one of the above payment methods within 10 (ten) days after the statement date. If for any reason, including short payments, the account is not paid in full within 30 days of the statement date you agree to be charged a $25 late fee for each month the balance is outstanding. The Responsible Party agrees to notify BHS Pharmacy in writing at the address listed below of any discrepancies or disputes within 15 days of the original statement date. If legal action is needed to recover any outstanding account balances, including late fees, the signed Responsible Party agrees to pay attorney fees, all related court costs and any collection agency fees in addition to the outstanding account balance. BHS is not responsible for insurance billing prior to notification of insurance coverage. BHS reserves the right to change the above conditions without notice.

RESPONSIBLE PARTY SIGNATURE_____DATE _____

RESPONSIBLE PARTY'S RELATIONSHIP TO RESIDENT _____

RETURN POLICY IN A COMMUNITY BASED CARE FACILITY

PREAMBLE

Unused medications result from medication order changes, from resident discharges, and mortality. Under appropriate circumstances, consultant pharmacists can reduce health care cost through the return and reuse of unused prescription medications. This statement addresses the legitimate return and reuse of medications in community base facilities when federal and state laws and regulations and facility policies and procedures are met. Reasonable mechanisms (for both the payer and the dispensing BHS Pharmacy) are in place for billing only the number of doses dispensed and crediting the number of doses returned that meet the Federal and State guidelines for returned drugs.

OUR POSITION

BHS supports the return and reuse of medications to the dispensing pharmacy to reduce the waste associated with unused medications in Community Based Facilities and to offer substantial cost savings to the health care system, provided specific drug product safeguards and appropriate guidelines are met.

BHS SUPPORTS THE RETURN AND REUSE OF MEDICATIONS TO THE DISPENSING PHARMACY ONLY IF THE FOLLOWING STATE BOARD OF PHARMACY GUIDELINES ARE MET:

- Consultant Pharmacist has made an on-site inspection of medication storage and deemed it to meet all guidelines set by State and Federal Laws and Regulations.
- Pharmacists shall **not** accept the return of a controlled substance.
- Drugs shall be in an unopened, tamper- evident container or blister card **and all doses are intact.**
- Drugs must be returned within 30 days of date dispensed. Anything older than 30 days will be destroyed. **No credit given**.
- The drugs or devices have remained at all times in control of a person trained and knowledgeable in the storage and administration of drugs in a long-term care facility or supervised living groups using the services of a consultant pharmacist. Drugs having left the facility either with the resident or a family member may only be returned for destruction. **Credit will not be given**.
- In the pharmacists' professional judgment, the unit dose package or full medication card meets the standards of the United States Pharmacopoeia for storage conditions including temperature, humidity, light sensitivity, chemical, and physical stability.
- Refrigerated items are not returnable. **Credit will not be given.**
- The drug or device has not been adulterated or misbranded.
- The drug has been stored in such a manner as to prevent contamination by a means that would affect the efficacy and toxicity of the drug. The drug labeling has not been altered or defaced, so that the identity of the drug, its potency, lot number, and expiration date are retrievable.
- If the drug is prepackaged, it shall not be mixed with drugs of different lot numbers and/or expiration dates unless the specific lot numbers are retrievable and the expiration dates accompany the drug.

CLARIFICATIONS

Under the Controlled Substance Act, controlled substances may only be returned between Drug Enforcement Administration registrants. Because Community Based Care facilities **are not** DEA registrants, pharmacies may not accept controlled substances returned from such facilities.

This statement uses the term "tamper-evident" instead of "unit dose" to convey that other types of packaging are acceptable for reuse as long as the tamper-evident seal is intact and the drug integrity is assured.

A service fee of $10.00 per prescription will be charged for processing medication returns.
This fee will only be assessed if a medication is eligible for return credit.

The undersigned party has read, and agrees to abide by, the Return Policy stated above:

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES – **Version 1, Effective 4/14/2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED FOR SPECIFIED PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the privacy regulations, BHS Pharmacy and all similar health care providers are required by federal law to maintain the privacy of protected health information ("PHI"). PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to provide individuals with notice of our legal duties and privacy practices, and your rights, with respect to PHI about you. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Please be advised that BHS Pharmacy (the "Pharmacy") may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you with medical care when you visit the Pharmacy. Under federal law, we may disclose your PHI to third parties for treatment (for example, your doctor or another doctor you may see, or another pharmacy you may use). We can disclose your PHI for payment (for example, we may disclose your PHI to your insurance provider in order to be reimbursed for our services rendered to you). We may use your PHI in the course of our pharmacy operations (for example, to facilitate claims payment reconciliation or to monitor the performance of our pharmacy). We may disclose to a family member, other relative, close personal friend or any person you identify, PHI relevant to that person's involvement in your care or payment related to your care. We may contact you to provide refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

There are some services provided by us through contracts with business associates. Examples include companies that assist us with claim submission or provide pharmacy system software and support. When these services are contracted for, we may disclose PHI about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. To protect PHI about you, we require the business associate to appropriately safeguard the PHI.

Unless other disclosures are required under federal law, state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your consent. Our practice may use or disclose your PHI in accordance with the specific requirements of the Privacy rules without us needing to obtain your consent or authorization if any of the following instances occur or disclosure is required: 1) by law; 2) by the FDA; 3) by public health authorities; 4) by law enforcement, protective or legal authorities; 5) by a health oversight agency for oversight activities authorized by law; 6) by a coroner or medical examiner; 7) by an organ or tissue procurement organization; 8) in the course of any judicial or administrative proceedings; 9) for victims of abuse, neglect or domestic violence; 10) to prevent a serious threat to the health or safety of a person or the public; or, 11) if deemed necessary by appropriate military command authorities to assure an appropriate military mission (if you are a member of the armed forces).

In the event the Pharmacy wishes to disclose your PHI to another entity besides those referenced above, we are required to obtain your written authorization. We would seek to obtain your authorization if we desired to release your PHI for reasons other than treatment, payment, health care operations or other reasons mentioned above. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending us a written revocation. However if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures.

You have the right to request restrictions on certain use and disclosures of your PHI to carry out treatment, payment or health care operations, or disclosures by the Pharmacy of your PHI to a family member, relative or a close personal friend. However, we are not required by federal law to agree to your requested restriction. You have the right to request access to, copies of, inspection of and amendment (when reasonably supported) to PHI about you contained in a designated record set (which will usually include prescription and billing records) for as long as the Pharmacy maintains the PHI. Under certain limited circumstances we may deny your requests. Additionally, if you desire, the Pharmacy can provide you with an accounting of disclosures that we have made of your PHI to third parties after 4/14/2003, except disclosures for treatment, payment or to other health care providers. If you request a copy of your PHI, you also have the ability to request that we send it to an alternative location and by alternative means, when reasonable. There may be a charge for the service.

If you would like to make any of the requests described above or would like additional information about the Pharmacy's privacy practices please write to: BHS Privacy Officer, 4085 W. 11th Ave. Suite #1, Eugene, OR 97402. If you have a dispute with the Pharmacy regarding a disclosure or use of your PHI, you may contact the BHS Privacy Officer or the Secretary of Health and Human Services.

_____
Facility Name

_____	_____	_____	_____
Printed Name	Signature	Patient Name	Date