SULLIVAN'S HEALTH CARE

Sullivan's Health Care

Enrollment Packet

Welcome to Sullivan's Health Care medication management services. We are honored that you have chosen us as your pharmacy provider. We look forward to partnering with you to address your medication management needs, and we will do all we can to ensure you receive the best pharmacy care possible.

We provide many specialized services such as medication compliance packaging, sterile/non-sterile compounding and delivery. We support residents in assisted living/group home settings, the communities in which they live, and individuals needing specialized services at home.

For a smooth transition, please fax the following information to **617-323-8776**:

- ☐ **Patient Intake form** (page 3)
  - ☐ Complete the intake form
  - ☐ Photocopy of both sides of prescription insurance card
  - ☐ Photocopy of power of attorney, if applicable
- ☐ **Medication Information** (page 4)
  - ☐ Transcribe medication information from current vials or packaging
- ☐ **Account Payment Form** (page 5)
  - ☐ Complete Payment Form

If you have any questions, please contact our staff **at 617-327-0210**.

Sincerely,

The Sullivan's Health Care Team

Facility/Home Services Agreement

Prescriptions

It is the policy of Sullivan's Health Care not to transfer prescriptions from other pharmacies but to obtain new prescriptions directly from patient's health care providers. Sullivan's Health Care requests the attached forms be completely filled out and allow up 5 business days to confirm receipt. We will then authenticate prescription orders once it is received from your health care providers.

Medication Billing

Sullivan's Health Care will not process medications requiring prior authorization for cash unless instructed by the resident / responsible payee. Medications filled as cash will become the responsibility of the resident /responsible payee. If the insurance company allows the prior authorization to be retroactively billed **back to the date of service (date the prescription was dispensed)**, Sullivan's Health Care will rebill and credit your charge account.

The resident/responsible payee shall be responsible for payment of all insurance copays and non-covered (cash) claims. The pharmacy does not determine insurance copayments. Insurance copayments are determined by the beneficiary's insurance plan.

Delivery

All maintenance medications shall be delivered on a scheduled basis as coordinated by the pharmacy with the facility/patient. Emergency prescription medications (ex. pain or antibiotics) will be delivered same day whenever possible. Non-emergent prescription medications and as needed medications will be delivered same day if in stock and called in before established cutoff time or the next day whenever possible. In circumstances when the pharmacy cannot deliver medication(s) (i.e. Act of God, out of stock, etc.) the pharmacy shall notify the facility/patient. At the time of delivery, the pharmacy is required by regulations to obtain a signature as receipt of delivered medications. There may be circumstances when the pharmacy will not require a signature (i.e. during pandemics such as COVID19).

Change in Resident/Patient Status

- If a resident/patient transfers out of a facility, becomes hospitalized or is discharged from a hospital/rehabilitation center, Sullivan's Health Care shall be notified immediately. We also require a discharge medication list from facility when discharged to ensure all medication changes are implemented.
- If a resident's/patient's insurance changes, please fax a photocopy of both sides of the new insurance card or pertinent documentation immediately to Sullivan's Health Care at 617-323-8776.
- If a resident's medical condition changes which may alter their medication regimen (i.e. new allergy), notify Sullivan's Health Care immediately

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Patient Intake Form

Instructions: Please complete the information below. If you have questions, please call 617-327-0210.

IMPORTANT: ATTACH PHOTOCOPIES OF BOTH SIDES OF INSURANCE CARDS

Facility Address (if applicable)

Name of Facility: ________________________________ Telephone # ______________________

Address: ____

Patient

Name: ____ Date of Birth ___/____/_____

Address: ____

Telephone # ______________________________ Social Security # ____--____--______

Physician(s) Please use additional sheet of paper if you have more than two physicians prescribing medications

PCP Name: __________________________________ Telephone # ______________________

Additional Physician Name: ________________________ Telephone # ______________________

Additional Physician Name: ________________________ Telephone # ______________________

Authorization Assignment of Benefits and Information Release

☐ I/we authorize any holder of medical and/or insurance information about the above named to disclose such information to Sullivan's Health Care. I further authorize Sullivan's Health Care to disclose any medical/or insurance information: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payer who may be responsible for payment or Pharmacy services. I authorize Sullivan's Health Care to request on my behalf all public and private insurance benefits for products/services and authorize payment be made directly to Sullivan's Health Care.

☐ I/we certify that I have had an opportunity to review Sullivan Health Care's Privacy Notice and Complaint Procedures included in this packet and ask questions to assist me in understanding the rights relative to the protection of the above-named person's health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.

Signature (of Patient or Power of Attorney)

Signature_________________________________ Date: ____/____/_________

Printed Name______________________________

Medication Information

Medication Name/Strength	Directions	Dosing Times	Provider

Previous Pharmacy:

Name____ Telephone# _______________________________________

Medication Allergies:

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Account Payment Form

Sullivan's Health Care provides courtesy charge accounts for customers utilizing our medication management services. Customers may choose to either (a) have a monthly invoice sent which must be paid within 30 days of receipt* or (b) authorize automatic monthly payments via credit card.

RESIDENT'S INFORMATION		
RESIDENT NAME:		DATE: / /
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE #		REFERRED BY:
RESIDENT'S RESPONSBILE PAYEE (IF APPLICABLE)-WHERE BILLING STATEMENTS ARE TO BE SENT		
REPRESENTATIVE PAYEE'S NAME:		RELATION:
ADDRESS:		
TELEPHONE #		Email:

A VALID CREDIT CARD IS REQUIRED TO SECURE THIS ACCOUNT.

PLEASE CHARGE MY: ☐ VISA ☐ MASTERCARD ☐DISCOVER ☐AMEX

CARD NUMBER: ____________________ EXPIRATION DATE _____/_____/________

CARD SECURITY CODE _________(3 DIGIT NUMBER FOUND ON THE BACK OF THE CARD)

CARDHOLDERS NAME **(PLEASE PRINT)** ____________________

AUTHORIZED SIGNATURE____________________ DATE _____/_____/________

This is an agreement between the above applicant and Sullivan's Health Care, Inc.

I/We, the undersigned, hereby accept responsibility for payment for purchases made on behalf of and/or for the above resident.

Choose one:

☐ I wish to pay automatically by credit card each month.

☐ I will mail in payment by check promptly after receipt of monthly statement. I understand my credit card information will only be used after Sullivan's Health Care notifies responsible party about non-payment of an outstanding balance

____________________ ____________________

Date of Agreement Signature of Patient / Responsible Payee

NOTICE: SEE NEXT PAGE FOR IMPORTANT INFORMATION REGARDING THE TERMS AND AGREEMENT

TERMS AND AGREEMENT
SULLIVAN'S HEALTH CARE ACCOUNT PAYMENT

BY APPLYING FOR A SULLIVAN'S HEALTH CARE CHARGE ACCOUNT, I AGREE TO THE TERMS DISCLOSED TO ME. I AGREE TO COMPLY WITH ALL TERMS ON THE CHARGE ACCOUNT AGREEMENT, A COPY WHICH WILL BE SENT TO ME UPON ACCEPTANCE OF THIS AGREEMENT. I AGREE TO RECEIVE ANY AND ALL DISCLOSURES, NOTICES AND CORRESPONDENCE RELATIVE TO THIS APPLICATION AND/OR SULLIVAN'S HEALTH CARE CHARGE ACCOUNT. I EXPRESSLY AUTHORIZE SULLIVAN'S HEALTH CARE TO REVIEW MY CREDIT HISTORY AND ANY OTHER INFORMATION I PROVIDE TO SULLIVAN'S HEALTH CARE RELATIVE TO THIS APPLICATION. ADDITIONALLY, I AUTHORIZE SULLIVAN'S HEALTH CARE TO OBTAIN SUBSEQUENT COPIES OF MY CREDIT HISTORY FOR THE PURPOSE OF AN UPDATE, REINSTATEMENT, AND EXTENSION OF CREDIT OR ANY LEGITIMATE PURPOSES ASSOSCIATED WITH MY ACCOUNT. UPON REQUEST, SULLIVAN'S HEALTH CARE WILL INFORM ME IF SUCH REPORT WAS REQUESTED AND SUPPLY TO ME THE NAME AND ADDRESS OF THE CONSUMER-REPORTING AGENCY. I CERTIFY THAT I AM AT LEAST 18 YEARS OLD AND THAT THE INFORMATION, WHICH I HAVE PROVIDED IS COMPLETE, TRUE AND ACCURATE

RESPONSIBLE PAYEE/RESIDENT UNDERSTANDS THAT IT IS HIS/HER OBLIGATION TO OBTAIN ANY AND ALL NECESSARY REFERRALS FROM HIS/HER PRIMARY CARE PHYSICIAN AND/OR TREATING PHYSICIAN REQUIRED BY HIS/HER INSURANCE COMPANY. RESPONSIBLE PARTY/RESIDENT UNDERSTANDS AND AGREES THAT IS IT HIS/HER OBLIGATION TO OBTAIN ALL NECESSARY INFORMATION REQUIRED BY HIS/HER INSURER. RESPONSIBLE PAYEE/RESIDENT UNDERSTANDS AND AGREES THAT IT IS HIS/HER OBLIGATION TO PAY FOR ANY AND ALL MEDICAL SERVICES RECEIVED FROM SULLIVAN'S HEALTH CARE REGARDLESS, WHETHER OR NOT HIS/HER INSURER APPROVES AND PAYS FOR SAID SERVICES. SHOULD RESPONSIBLE PAYEE/RESIDENT FAIL TO PAY FOR ANY UNPAID SERVICES, HE/SHE SHALL BE RESPONSIBLE FOR ALL SUMS DUE, PLUS COSTS OF COLLECTION, INCLUDING ATTORYNEYS FEES.

IN THE EVENT THAT ANY PROVISION OF THIS AGREEMENT IS FOUND TO BE INVALID, ALL OTHER PROVISIONS SHALL SURVIVE IN FULL FORCE AND EFFECT. THIS AGREEMENT REPRESENTS THE ENTIRE AGREEMENT OF THE PARTIES. IT IS MUTALLY UNDERSTOOD AND AGREED THAT ANY REPRESENTATION, PROMISE, CONDITION, INDUCEMENT OR WARRANTY, EXPRESS OR IMPLIED NOT INCLUDED IN WRITING IN THIS AGREEMENT SHALL NOT BE BINDING UPON ANY PART AND THAT THE AGREEMENT MAY NOT BE ALTERED, MODIFIED OR OTHERWISE CHANGED AT ANY TIME EXCEPT WITH THE CONSENT OF EACH OF THE PARTIES HERETO AND IN THE FORM OF AN ADDENEDUM TO THIS AGREEMENT. THIS AGREEMENT AND ALL CHARGES TO THE ACCOUNT SHALL BE GOVERNED BY THE STATUTORY AND COMMON LAWS OF THE COMMONWEALTH OF MASSACHUSETTS AND APPLICABLE FEDERAL LAW.

THE SULLIVAN'S HEALTH CARE CHARGE ACCOUNT IS ONLY AVAILABLE TO APPLICANTS RESIDING IN THE UNITED STATES WHO ARE U.S. CITIZENS OR ALIENS WITH PERMANENT RESIDENT STATUS.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PHARMACEUTICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our pharmacy is to give our patients this notice (in paper or electronically as the patient wishes) of our legal duties and privacy practices concerning their Protected Health Information, and also to tell our patients about their rights under HIPAA.

I. **Uses and Disclosures of Protected Health Information**. There are two categories for the use and disclosure of our patients' Protected Health Information: (A.) information that we can use and disclose without the patient's prior consent; and (B.) information that we cannot use or disclose without the patient's prior authorization.

A. Patients' Prior Consent Not Required.

1) Treatment. In the first category, we are permitted to use and disclose our patients' Protected Health Information in connection with their medical treatment in situations such as allowing a family member/relative, close personal friend or other person involved in the patient's health care to pick up the patient's prescriptions and to receive Protected Health Information that is directly related to the patient's care. In doing so, we are to use our professional judgment and experience with common practice in determining what is in the patient's best interest. Other examples include sending information about a patient's prescriptions to the patient's primary care physician, specialist, or to a hospital where the patient is receiving care, particularly if the patient has suffered a health emergency.

2) Payment. If a patient is covered by a pharmacy benefit plan, we are entitled to send Protected Health Care Information to the plan or to another business entity involved in our billing system describing the medication or health care equipment we have dispensed so that we can be paid.

3) Health Care Operations. In addition, we can provide Protected Health Information for health care operations such as evaluations of the quality of our patients' health care in order to improve the success of treatment programs. Other examples include reviews of health care professionals, insurance premium rating, legal and auditing functions, and business planning and management.

4) Other Permitted Uses and Disclosures. There are a number of other specified purposes for which we may disclose a patient's Protected Health Information without the patient's prior consent (but with certain restrictions). Examples include public health activities; situations where there may be abuse, neglect or domestic violence; in connection with health oversight activities; in the course of judicial or administrative proceedings; in response to law enforcement inquiries; in the event of death; where organ donations are involved; in support of research studies; where there is a serious threat to health and safety; in cases of military or

veterans' activities; where national security is involved; for determinations of medical suitability; for government programs for public benefit; for workers' compensation proceedings; when our records are being audited; when medical emergencies occur; and when we communicate with our patients orally or in writing about refilling prescriptions, about generic drugs that may be appropriate for a patient's treatment, or about alternative therapies.

B. Patients' Prior Authorization Required.

For purposes other than those mentioned above, we are required to ask for our patients' written authorizations before using or disclosing any of their Protected Health Information. If we request an authorization, any of our patients may decline to agree, and if a patient gives us an authorization, the patient has the right to revoke the authorization and by doing so, stop any future uses and disclosures of the patient's health information that the authorization covered. An example of a situation where the patient's prior authorization would be required would be if we wish to conduct a marketing program that would involve the use of Protected Health Information.

II. **Patients' Rights**. HIPAA and the Regulations provide our patients with rights concerning their Protected Health Information. With limited exceptions (which are subject to review) each patient has the right to the following:

1) Patient's Record. Each patient can obtain a copy of his or her Protected Health Information upon written request. The only charge will be based on our cost in responding to the request. The amount of the charge will vary depending on the format the patient requests and whether the patient wants the record or a summary, and whether it is to be delivered by mail or otherwise. The patient will be told of the fee when the patient's request is received. If at the time of the patient's request we maintain an electronic health record with respect to Protected Health Information, the patient has a right to obtain a copy of the patient's Protected Health Information in electronic form and to direct that the copy directed to a clearly identified person or entity.

2) Accounting for Disclosures. Each patient can, upon written request, obtain a list of the disclosures of the patient's Protected Health Information that have occurred within the 6 years preceding the request, except for disclosures made for the purposes of treatment, payment or health care operations and certain others. There will be no charge for the first request in any 12-month period, but we are entitled to charge a reasonable cost-based fee for additional requests made in the same period of time. However, if at the time of the patient's request we maintain an electronic health record with respect to Protected Health Information, the foregoing exception will not apply and the period covered for the accounting will be the 3 years preceding the request.

3) Amendments. Each patient may ask to change the record of his or her own Protected Health Information upon written request explaining why the change should be made.

We will review the request, but may decline to make the change if in our professional judgment we conclude that the record should not be changed.

4) Communications. Upon written request, each patient can ask us to communicate with him or her about their own Protected Health Information in a confidential manner such as by sending mail to an address other than the home address or using a particular telephone number.

5) Special Restrictions. Upon written request, each patient can ask us to adopt special restrictions that further limit our use and disclosure of the patient's Protected Health Information (except where use and disclosure are required of us by law or in emergency circumstances). We will consider the request; but in accordance with HIPAA we are not required to agree to with the request; provided, however, we will comply with a patient's request to restrict the disclosure of Protected Health Information to a health plan if the disclosure is for payment or health care operations (excluding treatment), and the disclosure pertains solely to a health care item or service for which we have been paid out of pocket in full.

6) Complaints. If a patient believes that we have violated the patient's rights as to the patient's Protected Health Information under HIPAA or if a patient disagrees with a decision we made about access to the patient's Protected Health Information, the patient has the right to file a written complaint with our Contact Person listed below. Our Contact Person is required to investigate, and if possible, to resolve each such complaint, and to advise the patient accordingly. The patient also has the right to send a written complaint to the U.S. Department of Health and Human Services. Under no circumstances will any patient be retaliated against by this pharmacy for filing a complaint.

We are required by law to protect the privacy of our patients' Protected Health Information, to provide this notice about our privacy practices, and follow the privacy practices that are described in this notice. We reserve the right to make changes in our privacy practices that will apply to all the Protected Health Information we maintain. A new notice will be available upon request before any significant change is made.

Complaint Procedures

You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination, or unreasonable interruption of services. The contact information is listed below.

Contact Person: Pharmacy Manager
Telephone # 617-327-0210
Email: info@sullivanshealthcare.com

Compliance Packaging Options for Residential Patients

(Long Term Care at Home)

Medicine on time (30 days)– Color Coded calendar cards based on time of day medication is taken

Weekly Trifold (28 days) – Sealed packaging with Morning, Noon, Evening and Bedtime medications dispensed as four 7-day cards.

PARATA (30 days) – Cellophane packets with date and time on each packet rolled to be dispensed chronologically

All non-scheduled (as needed) medications will be in blister cards or dispensed in respective packaging