



18800 142nd Ave NE, Suite 4B
Woodinville WA 98072
425-455-2123

New Client Information

Date _____

Facility Name _____ Phone _____

Residents Full Name _____

Gender _____

Allergies _____ No Known Allergies

Date of Birth _____

Chronic Medical Conditions _____

Primary Care Provider _____ Phone _____

Social Security Number _____ Medicare Number _____

Previous Pharmacy _____ Phone _____

Pharmacy Insurance _____ Phone _____

Rx Group # _____ RxBIN # _____

RxPCN # _____ RxID # _____

Other Pharmacy Insurance _____

Phone _____

Rx Group # _____ RxBIN # _____

RxPCN # _____ RxID # _____

OR ATTACH COPIES OF
FRONT AND BACK OF
PATIENT INSURANCE CARDS

Responsible Party _____

Relationship _____ Phone _____

Previous Pharmacy _____ Phone _____

List of residents current medications or attach MAR or medication discharge summary



18800 142nd Ave NE, Suite 4B
Woodinville WA 98072
425-455-2123

Pharmacy Services Provider Agreement

I am authorizing Bellegrove Pharmacy to provide all medications, associated products and services for:

Resident Name: _____

A resident of: _____

I certify that I have the legal authority to sign this agreement on behalf of the facility resident and I understand that by signing this agreement I will become financially responsible to pay the usual and customary fee or insurance company, Medicare or Medicaid determined patient responsible co-payments for all medications, products and services provided for the resident. I acknowledge that I am responsible for any and all payments during and after the residents stay at the facility.

I understand that the facilities staff or medical providers are authorized to order and accept delivery of medications, supplies and associated products for the resident. I understand that medications and supplies, once delivered to the resident or facility, cannot be returned to the pharmacy as described in WAC 246-869-130.

I request that the pharmacy dispense medications in non-child proof containers, commonly known as easy open vials, bubble packs, or multi packs for the duration of the residents stay in the facility.

I understand that statements printed monthly are for medications sent the previous month. Should the resident move out the facility or pass away I am still obligated to pay the final balance by the end of the statement month. If full payments are not received by the end of the month, I agree to pay a finance charge of 1.5% per month. I understand that if no payment or partial payment were received for the previous month, Bellegrove Pharmacy may refuse to provide medications, associated products or services for the resident. If your account becomes 90 or more days delinquent, Bellegrove Pharmacy may send your account to collection. I agree to pay all costs of collection, including court costs and attorney fees, for all delinquent balances. I agree to pay the Pharmacy a fee of \$25.00 as described in RCW 62A.3-515 (b)(1) if for any reason a check issued for the resident is not honored by the financial institution.

Financially Responsible Party (required information)

| | |
|--------------------------|-------------------|
| Responsible Party: _____ | |
| Relationship: _____ | Power of Attorney |
| Address: _____ | |
| City: _____ | State: _____ |
| Phone: _____ | E-mail: _____ |

Credit Card Payment Authorization

| | |
|---|--|
| I authorize Bellegrove Pharmacy to charge payments for medications, products or services to the credit card listed below. I acknowledge that the pharmacy will store the credit card information on a secure server for billing purposes. | |
| Credit Card Number: _____ | |
| Name on Card: _____ | |
| Expiration Date: _____ | Security Code: _____ |
| Billing Address: _____ | <input type="checkbox"/> Same as above |
| City: _____ | State: _____ Zip Code: _____ |

By signing this agreement, I acknowledge that I have received a copy of Bellegrove Pharmacy privacy policies and reviewed them. I further acknowledge that I have read and understand the terms of this Pharmacy Services Provider Agreement.

Signature: _____ Date: _____

Printed Name: _____

Bellegrove Pharmacy provides specialized goods and services for residents of long-term care facilities. These goods and services include, but are not limited to, specialized packaging, delivery, and medical records. We have been proudly providing prescription medications and medical services to the Western Washington community since 1977.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED BY BELLEGROVE PHARMACY. PLEASE REVIEW IT CAREFULLY.

Protecting Medical Information

Bellegrove Pharmacy is required by the Health Insurance Accountability and Portability Act of 1996 ("HIPAA") to maintain the privacy of your Protected Health Information (PHI). PHI is considered to be your medical records and other health information that identifies you. This includes any information we keep, use, or disclose in any form, whether electronically, on paper, or orally. As required by HIPAA, we must provide this notice to you and make a good faith effort to obtain your acknowledgement that you have received it. This notice explains how we will use your PHI while maintaining your privacy, explains your rights with respect to PHI, and explains our duty to abide by the terms of the notice and any updates that we make in the future.

Our Use of Your Information

Under the law we are permitted to use and disclose your PHI without your authorization for the purposes of treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples are when we contact your physician or other health care providers to obtain refill authorizations, ask questions about medication doses, inform them of potential drug interactions, or determine validity of prescription orders. We may also use and disclose your information when your physician, health care provider, or another pharmacy contacts us and says that you have requested them to provide health care services.

Payment means such activities as obtaining payment for services, confirming health plan coverage, and billing or collection activities. Examples are electronically billing your insurance company or health plan at the time we fill your prescriptions. Insurance companies or health plans may also contact us about services we provide to you.

Health care operations include business aspects of running our pharmacy, such as planning, financial analysis, and customer service. An example is when we look at records to evaluate how well our pharmacists and technicians provide service to you.

We may also use your PHI without your authorization to provide you with refill reminders; information about alternatives to medications or services you receive through our pharmacy; or notices of health screenings, special events, or other wellness activities we may conduct.

We may release information about you to a family member or others involved in your medical care. Examples include if a family member picks up a prescription for you or if you have a nursing aide that assists you with your medications.

Whenever anyone receives PHI on your behalf we will provide only the minimum amount of information necessary to insure your quality of care. We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena.

Our pharmacy may use and disclose your PHI when necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public.

Any other uses and disclosures other than those provided for above (or as otherwise permitted or required by law) will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except for actions we have already taken relying on your authorization.

Your Rights

You have the following rights with respect to your PHI, which you can exercise by presenting a written request to the Privacy Official.

The right to request restrictions on certain uses and disclosures, including any group of persons or person identified by you. We are, however, not required to agree to a requested restriction.

The right to reasonable requests to receive confidential communications from us by alternative means or at alternative locations.

The right to inspect and copy your PHI. We reserve the right to schedule this activity and charge a reasonable fee to gather the information and for copy expenses.

The right to amend your PHI.

The right to receive a list of disclosures of your PHI when you complete our request form.

The right to obtain a paper copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Effective Date of Notice

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new policy provisions effective all protected health information that we maintain. We will post any revised notice in our pharmacy and you may receive a written copy of a revised notice by requesting orally or in writing.

Complaint Process

If you believe your privacy protections have been violated you have the right to file a formal, written complaint with us at the address shown in the contact information, or with the Department of Health & Human Services, Office of Civil Rights. Bellegrove Pharmacy will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
Bellegrove Pharmacy
18800 142nd Ave NE
Suite 4B
Woodinville WA 98072
425-455-2123