NOTCH PHARMACY
44 Main St. Suite 201
Richford, VT 05476
Phone: 802-255-5530
Fax: 802-255-5539

MULTI-DOSAGE PACKAGING AGREEMENT

My signature on this form acknowledges that I have entered into a voluntary multi-dose packaging agreement with NOTCH Pharmacy. Terms of this agreement are as follows:

- NOTCH will package my prescription medications in a 28 day multi-dose format.
- NOTCH will only bill my insurance carrier in accordance with their contracted terms and conditions and my co-payment responsibilities will reflect this billing cycle.
- I will be auto billed once a month for copays.
- This is a voluntary agreement and may be terminated at any time.

Patient's Name:_____

Signature:_____

Date of Birth:_____

Date:_____

If not signed by patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or Conservator of Patient
- Power of Attorney for Patient
- Spouse or Person Financially Responsible (where information solely for purpose of processing application for dependent health care coverage).
- Other_____

Once we receive the completed information, we will request new prescriptions from your medical providers and contact you to confirm the start date for your Multi-Dosage Packaging.

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PATIENT INFORMATION FORM

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME: _____ CELL: _____

GENDER _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PRESCRIPTION INSURANCE: _____ BIN _____ PCN: _____ GROUP: _____

MEMBER ID# _____ MEDICARE ID# _____

ALLERGIES: _____

DRUG REACTIONS: _____

CHRONIC CONDITIONS OR DISEASE STATE: _____

Do you have any other prescription medications, vitamins or over the counter cough and cold, allergy or pain medication?
Yes_____ No_____

If yes, please list below and how often you take it:
(i.e. Tylenol as needed or Baby Aspirin – one each day)

_____

_____

_____

METHOD OF DELIVERY: PICK UP AT PHARMACY _____ MAIL_____

PERSON RESPOSIBLE FOR BILLS:_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

GUARDIAN _____

OTHER INSURANCE _____

POLICY NUMBER _____

PHYSICIAN _____

PHONE NUMBER _____

SUPPLIES NEEDED _____

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ASSIGNMENT OF INSURANCE BENEFITS FORM
Multi-Dose Packaging

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE ON MY BEHALF TO NOTCH PHARMACY FOR ANY PRESCRIPTIONS OR SUPPLIES FURNISHED ME BY THE PHARMACY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services*. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier.

My signature authorizes the automatic filling and refilling of all ordered medications. As a Multi-dose packaged customer, my medications will be packaged in 28 day cycles, including any medications prescribed to be taken as needed. New prescriptions and refills will be filled and billed according to my established packaging schedule.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, INCLUDING COPAYMENTS AND COSTS NOT COVERED BY SAID INSURANCE.

My signature on this form also acknowledges receipt of the *NOTCH NOTICE OF PRIVACY PRACTICES* and the *CMS MEDICARE DMEPOS SUPPLIER STANDARDS.*

Patient's Name:_____

Signature:_____

Print Name:_____

Date:_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)
- ☐ Other:_____

NOTCH

NOTCH PHARMACY Patient Agreement

Simplify My Meds®

We are pleased to welcome you to **Simplify My Meds®**, our coordinated refill program.

Advantages of participating in the program include:

- Increased convenience—a single monthly trip to the pharmacy.
- Peace of mind from being able to get medications on time and in one order.
- More personal contact with the pharmacist to ask questions and discuss medications.
- Increased understanding of your medication, its purpose, potential side effects and costs.
- Your prescription records will be easily updated to reflect changes to therapy made by doctors or upon hospital discharge.

I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the Simplify My Meds program.

I hereby agree:

- To accept a phone call each month from the pharmacy to discuss my prescription refills.
- To pick up medications on my assigned refill date (or be available for delivery, if applicable).
- If necessary, to pay an extra co-pay one time for each medication in order to make all refills due on the same day.
- To keep an open dialogue with my pharmacist regarding doctor appointments, hospital/urgent care visits, and changes in my health status.

I have read this document, understand it, and have had all questions answered.

_____	_____
Patient Name (*please print*)	Date of Birth
_____	_____
Patient Signature	Date
_____	_____
Pharmacist Signature	Date

Credit Card Authorization Form

NOTCH Pharmacy accepts Visa, MasterCard, Discover and American Express
Please complete the information listed below.

Please **PRINT** all information. Thank you!

Billing Information
Full Name:_____
(Enter your name as it appears on the credit card)

Billing Address:_____
(Enter the address as it appears on your credit card statements)

City: State: Zip:_____

Country (if other than the United States) :_____

Billing Address Phone Number:_____

Credit Card Details
Circle type of card: VISA MasterCard Discover American Express

Card Number:_____

Expiration Date (month and year):_____

Security Code: _____

I authorize NOTCH Pharmacy to keep this credit card information on file. I understand this information will be used to process payments due on my account for Pharmacy purchases provided by NOTCH Pharmacy. I will notify NOTCH Pharmacy of any changes or when I no longer wish to keep my card on file.

Signature of Cardholder:_____

Signature Date: ____/____/____ Phone #: (_____)_____

Note: Your credit card statement will show a charge from Northern Tier Center for Health 44 Main Street, Suite 200, Richford, VT 05476 Phone: (802)255-5560 Fax: (802)255-5569

You will receive a receipt for your purchase via mail once your credit card information has been processed.

NOTCH

Northern Tier Center for Health
44 Main Street, Suite 200
Richford, VT 05476

Outreach and Enrollment Dept.
Phone (802) 255-5573
Fax (802) 255-5506

Financial Assistance Program Application

Applicant

Name: Last _____ First _____ MI ____

Date of Birth _____ SS# _____

Single___ Married___ Divorced___ Separated___ Widowed___

Mailing Address _____

City_____ ZIP_____ Phone_____

Physical 911 Address (cannot be PO Box)

Street Address _____

City_____ ZIP_____

Co-Applicant (as listed on Income Tax Return)

Name: Last _____ First _____ MI ____

Date of Birth _____ SS# _____

Children/Dependents (as listed on Tax Return)

Name	Relationship	Birth Date	Social Security #
1.			
2.			
3.			
4.			
5.			

Please Provide a full copy of your most recent Income Tax Return (this must include gross income and names of dependents) If you do not file an Income Tax Return we will accept one of the following:
Social Security Benefit Statement, 3 current paystubs, or employers verification of income (hours worked and wage per hour) on company letterhead, or a **Self Declaration of Income** (the Self Declaration will only apply to patient completing form).

By Signing below I authorize NOTCH to release the financial information I've provided with this application to Northwestern Medical Center, Inc. (NMC) to apply for additional Financial Assistance being offered by NMC for NMC services. Approval or denial of NMC Financial Assistance Program is not contingent upon NOTCH Financial Assistance approval.

To the best of my knowledge, the information provided with this application is true and correct. I agree to inform NOTCH of any changes in my employment or financial status. If the information proves to be incorrect, I understand that the discount provided to me will be terminated. I also give permission for NOTCH to contact my employer or any other source to verify income when necessary.

Signature of Applicant _____ Date _____

Do you or any members of your household have Health Insurance? YES or NO

If you are a woman age 21-64 you maybe eligible for Ladies First. It is a free health benefit that covers breast, cervical, heart health screenings.

I am interested in Ladies First for myself, or family member. YES or NO

FOR CENTER USE ONLY: *Gross Monthly income* _____ *Gross Annual income* _____

*Authorized Initials*_____ *Sliding Fee Medical/Dental* _____ *Approval/Denial Date*_____ *to* _____

NMC Sliding Fee Program Applicant Name: _____

NET WORTH

Assets	
Balance in checking accounts	
Balance in savings accounts	
Certificate of Deposits (CD's)	
Stocks	
IRAs, 401ks, & other Retirement funds	
Market value of Real Estate (other than primary residence)	
Market value of Autos	
Other Assets (describe):	
Total Assets	$

Liabilities	
Outstanding balance on credit cards	
Outstanding balance on auto loans	
Outstanding balance on Real Estate loans (other than primary residence)	
Other Debt (describe):	
Total Liabilities	$
NET WORTH (total assets minus total liabilities)	**$**

MONTHLY INCOME & EXPENSES

Income *(MUST provide documentation to support ALL Income)*	
Gross Salaries/Wages (before taxes & deductions)	
Social Security payments received	
Pension or retirement payments received	
Interest Income	
Divident Income	
Unemployment/workers' compensation payments received	
Rental Income	
Child Support/Alimony payments received	
Other (describe):	
Total Monthly Income	$

Expenses	
Mortgage/Rent	
Property Taxes	
Auto Loans	
Credit Card Payments	
Utilities	
Child Support/Alimony Payments	
Insurance, auto, home, health	
Medical expenses	
Other Living Expenses- telephone, heat, food, gas, water, rubbish, sewer	
Other (describe):	
Total Monthly Expenses	$
TOTAL MONTHLY HOUSEHOLD NET INCOME (Income less Expenses)	**$**

NOTCH
Alburg – Enosburg – Richford – Swanton – St.Albans
44 Main Street Suite 200
Richford, Vt. 05476
Phone (802) 255-5580 Fax (802) 255-5589

Self Declaration of Income

ONLY GOOD FOR 1 PERSON

I, _____, declare that I have been working and receiving payment in cash in the amount of $ _____ per (**circle one**) day, week, two-weeks, or month. I have no check stubs or other documentation to prove my earnings.

I, _____, declare that I have no employment and do not have income of any kind.

1. How do you pay for food _____
2. How do you pay for heat and rent _____
3. Do you receive Food Stamps _____
4. Do you receive child support/alimony _____
5. Do you receive social security _____
6. Did you file income tax last year – (IF YES PLEASE PROVIDE A COPY – IF CURRENTLY NOT WORKING PLEASE PROVIDE EXPLANATION)

_____

_____

Signature: _____

Date: _____

NOTCH
Northern Tier Center for Health
Alburg • Enosburg • Richford • St Albans • Swanton

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Electronic Exchange of your Health Information: In some instances, we may transfer health information about you electronically to other health care providers who are providing you treatment. Your health information may also be made available through the Vermont Health Information Exchange (VHIE) which is a health information network operated by VITL, Inc. Your treating health care providers may only access your health information through the VHIE if you have provided specific written consent for their access unless you are in need of emergency treatment. For information about the VHIE, see www.vitl.net.

Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with the opportunity to object to such uses or

disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable references of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Required by Law: We may use or disclose your health information when required to do so by law.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Required authorizations include most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in the Notice will be made only with an authorization from you. We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) You will receive a copy of your request within 30 days.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your heath information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Fundraising: You have the right to opt out of fundraising communications.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

You have the right to restrict certain disclosures to your health plan where you pay out of pocket in full for a

healthcare item or service. If you do so, you are responsible for notifying a downstream Health Information Exchange of the restriction.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Breach Notice: We will notify you of a breach of unsecured health information.

Questions and Complaints

If you want more information about our privacy practices or have questions, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. Also, you may submit a written complaint to the U.S. Dept. of Health and Human Services. We will provide you with their address upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: NOTCH Privacy Officer, 44 Main Street, Richford, VT 0476 Phone: 802-255-5560 Fax: 802-255-5569

Notice of Privacy Practices

revised 10/25/13