RED ROCK PHARMACY

PATIENT PACKET

welcome

Welcome to the Red Rock Pharmacy family. We are pleased to have been selected as your specialty pharmacy provider. This packet contains our contact information and notice of privacy practices. It also contains our Patient Information sheet, Agreement for Services, and Convenient Payment Options. These are forms for you to fill out and return to us.

Red Rock Pharmacy is a closed door pharmacy providing medication to Assisted Living Facilities, Hospice Companies and Group Homes. We pride ourselves on our deep-rooted relationships with many physicians and other health care providers as well as our devotion to the care of our patients and all of their needs. Red Rock Pharmacy is committed to you and ensuring that all of your pharmaceutical needs are met to your satisfaction.

Our pricing and service is unmatched and our goal is to work with your team in a collaborative effort to reduce costs and increase services. The principles of partnership, collaboration, integrity, commitment, and customer focus are a part of everything we do, whether we're engaged with facilities or individual customers. Our goal is to provide the most advanced, cost effective and convenient ways of administering and delivering medications to patients.

Welcome and thank you for choosing Red Rock Pharmacy.

Sincerely,
Red Rock Pharmacy Staff

RED ROCK Pharmacy

BILLING CONTACT INFORMATION

RED ROCK PHARMACY

phone: 801.433.9500

fax1: 801.679.4748

fax2: 801.433.9333

email: order@redrockrx.com

HOURS OF OPERATION

BILLING OFFICE

weekdays: 8:30am - 5pm

PHARMACY

weekdays: 8am - 7pm

weekends: 9am - 5pm

BILLING AND CO-PAY QUESTIONS

phone: 385.315.5770

email: accounting@redrockrx.com

RED ROCK Pharmacy

NOTICE OF PRIVACY PRACTICES

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.

Our Pledge To You. Your health information -- which means any written or oral information that we create or receive that describes your health condition, treatment or payments -- is personal. Therefore, the Pharmacy pledges to protect your health information as required by law. We give you this Privacy Notice to tell you (1) how we will use and disclose your "protected" health information, or "PHI" and (2) how you can exercise certain individual rights related to your PHI as a Patient of Red Rock Pharmacy ("the Pharmacy"). Please note that if any of your PHI qualifies as mental health records, alcohol and drug treatment records, communicable disease records or genetic test records, we will safeguard these records as "Special PHI" which will be disclosed only with your prior express written authorization, pursuant to a valid court order or as otherwise required by law. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices.

I. HOW WE WILL USE AND DISCLOSE YOUR PHI

A. **TO PROVIDE TREATMENT.** We may use and disclose your PHI to provide, coordinate, or manage your treatment, medications and services you received from the Pharmacy. For example, we may contact you regarding medications, equipment, supplies, compliance programs such as drug recommendations, therapeutic substitutions, refill reminders or other products or service recommendations, such as specialty and infusion therapies, counseling and drug utilization review (DUR), product recalls or disease statement management.

B. **TO OBTAIN PAYMENT.** We may also use and disclose your PHI, as needed, to obtain payment for services that we provide to you. This may include certain communications to your health insurer, a pharmacy benefit manager, health plan, or other health care payor, to confirm (1) your eligibility for health benefits, (2) the medical necessity of a particular service or procedure, or (3) any prior authorization or utilization review requirements. We will bill your third party payer for the cost of medications, equipment and supplies dispensed to you. The information on or accompanying the bill may include information that identifies you as well as the medications you are taking. We may also disclose your PHI to another provider involved in your care for the other provider's payment activities. For example, this may include disclosure of demographic information to another physician practice that is involved in your care, or to a hospital where you were recently hospitalized, for payment purposes.

C. **TO PERFORM HEALTH CARE OPERATIONS.** We may also use or disclose your PHI, as necessary, to carry on our day-to-day health care operations, and to provide quality care to all of our Patients, but only on a "need to know" basis. These health care operations may include such activities as: quality improvement; physician and employee reviews; health professional training programs, including those in which students, trainees, or practitioners in health care learn under supervision; accreditation; certification; licensing or credentialing activities; compliance reviews and audits; defending a legal or administrative claim; business management development; and other administrative activities. In certain situations, we may also disclose your PHI to another health care provider or health plan to conduct their own particular health care operation requirements.

D. **TO CONTACT YOU.** To support our treatment, payment and health care operations, we may also contact you at home, either by telephone or mail, from time to time (1) to remind you of prescription fills and refills, or an upcoming appointment date or (2) to ask you to return a call to the Pharmacy unless you ask us, in writing, to use alternative means to communicate with you regarding these matters. We may also contact you by telephone to inform you of specific test results or treatment plans, but only with your prior written authorization.

RED ROCK Pharmacy

E. TO BE IN CONTACT WITH YOUR FAMILY OR FRIENDS. Additionally, we may also disclose certain of your PHI to your family members or other relatives, a close personal friend, or any other person specified by you from time to time, but only if the PHI is directly related (1) to the person's involvement in your treatment or related payments, or (2) to notify the person of your physical location or a sudden change in your condition, while receiving treatment at our office. Although you have a right to request reasonable restrictions on these disclosures, we will only be able to grant those restrictions that are reasonable and not too difficult to administer, none of which would apply in the case of an emergency.

F. TO CONDUCT RESEARCH. Under certain circumstances, we may use and disclose certain of your PHI for research purposes, but only if the research is subject to special approval procedures and the necessary rules governing uses and disclosures are agreed to by the researchers. For example, a research project may compare two different medications used to treat a particular condition in two different groups of Patients by comparing the Patients' health and recovery in one group with the second group. Any other research will require your written authorization.

G. ACCORDING TO LAWS THAT REQUIRE OR PERMIT DISCLOSURE. We may disclose your PHI when we are required or permitted to do so by any federal, state or local law, as follows:

1. WHEN THERE ARE RISKS TO PUBLIC HEALTH. We may disclose your PHI to (1) report disease, injury or disability; (2) report vital events such as births and deaths; (3) conduct public health activities; (4) collect and track FDA-related events and defects; (5) notify appropriate persons regarding communicable disease concerns; or (6) inform employers about particular workforce issues.

2. TO REPORT SUSPECTED ABUSE, NEGLECT OR DOMESTIC VIOLENCE. We may notify government authorities if we believe that a Patient is the victim of abuse, neglect or domestic violence, but only when specifically required or authorized by law or when the Patient agrees to the disclosure.

3. TO CONDUCT HEALTH OVERSIGHT ACTIVITIES. We may disclose your PHI to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight, but we will not disclose your PHI if you are the subject of an investigation and your PHI is not directly related to your receipt of health care or public benefits.

4. IN CONNECTION WITH JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal. In certain circumstances, we may disclose your PHI in response to a subpoena if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

5. FOR LAW ENFORCEMENT PURPOSES. We may disclose your PHI to a law enforcement official to, among other things, (1) report certain types of wounds or physical injuries, (2) identify or locate certain individuals, (3) report limited information if you are the victim of a crime or if your health care was the result of criminal activity, but only to the extent required or permitted by law.

6. TO CORONERS, FUNERAL DIRECTORS, AND FOR ORGAN DONATION. We may disclose PHI to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties. We may also disclose PHI to a funeral director in order to permit the funeral director to carry out their duties. PHI may also be disclosed for organ, eye or tissue donation purposes.

7. IN THE EVENT OF A SERIOUS THREAT TO HEALTH OR SAFETY, OR FOR SPECIFIC GOVERNMENT FUNCTIONS. We may, consistent with applicable law and ethical standards of conduct, use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public, or for certain other specified government functions permitted by law.

8. FOR WORKER'S COMPENSATION. We may disclose your PHI to comply with worker's compensation laws or similar programs.

9. TO COMMUNICATE WITH YOU REGARDING YOUR TREATMENT. We may also communicate information to you, from time to time, that may encourage you to use or purchase a particular product or service, but only as it relates to your treatment and only when permitted by HIPAA.

H. WITH YOUR PRIOR EXPRESS WRITTEN AUTHORIZATION. Other than as stated above, we will not disclose your PHI, or more importantly, your Special PHI, without first obtaining your express written authorization. We will not use or disclose your PHI in any of the following situations without your written authorization:

1. Uses and disclosures of Special PHI (if recorded by us in the medical record) except to carry out your treatment, payment or health care operations, to the extent permitted or required by law;

2. Uses and disclosures of PHI to conduct certain marketing activities that may encourage you to use or purchase a particular product or service for which HIPAA requires your prior express written authorization;

3. Disclosures of PHI that constitutes a sale of your PHI under HIPAA;

4. Uses and disclosures of certain PHI for fund raising purposes that are not otherwise permitted by HIPAA;

5. Psychotherapy notes; and

6. Other uses and disclosures not described in this Notice.

II. YOUR INDIVIDUAL RIGHTS CONCERNING YOUR PHI

A. THE RIGHT TO REQUEST RESTRICTIONS ON HOW WE USE AND DISCLOSE YOUR PHI. You may ask us not to use or disclose certain parts of your PHI but only if the request is reasonable. For example, if you pay for a particular service in full, out-of-pocket, on the date of service, you may ask us not to disclose any related PHI to your health plan. You may also ask us not to disclose your PHI to certain family members or friends who may be involved in your care or for other notification purposes described in this Privacy Notice, or how you would us to communicate with you regarding upcoming appointments, treatment alternatives and the like by contacting you at a telephone number or address other than at home. Please note that we are only required to agree to those restrictions that are reasonable and which are not too difficult for us to administer. We will notify you if we deny any part of your request, but if we are able to agree to a particular restriction, we will communicate and comply with your request, except in the case of an emergency. Under certain circumstances, we may choose to terminate our agreement to a restriction if it becomes too burdensome to carry out. Finally, please note that it is your obligation to notify us if you wish to change or update these restrictions after your visit by contacting the Privacy Officer directly.

B. THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PHI. You may request to receive communications of PHI from us by alternative means or at alternative locations, and we will work with you to reasonably accommodate your request. For example, if you prefer to receive communications of PHI from us only at a certain address, phone number or other method, you may request such a method.

C. THE RIGHT TO INSPECT AND COPY YOUR PHI. You may inspect and obtain a copy of your PHI that we have created or received as we provide your treatment or obtain payment for your treatment. A copy may be made available to you either in paper or electronic format if we use an electronic health format. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law prohibiting access. Depending on the circumstances, you may have the right to request a second review if our Privacy Officer denies your request to access your PHI. Please note that you may not inspect or copy your PHI if your physician believes that the access requested is likely to endanger your life or safety or that of another person, or if it is likely to cause substantial harm to another person referenced within the information. As before, you have the right to request a second review of this decision. To inspect and copy your PHI, you must submit a written request to the Privacy Officer. We may charge you a fee for the reasonable costs that we incur in processing your request.

D. THE RIGHT TO REQUEST AMENDMENTS TO YOUR PHI. You may request that your PHI be amended so long as it is a part of our official Patient Record. All such requests must be in writing and directed to our Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may respond to your statement in writing and provide you with a copy.

E. THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PHI. You have the right to request an accounting of those disclosures of your PHI that we have made for reasons other than those for treatment, payment and health care operations, which are specified in Section II (A-C) above. The accounting is not required to report PHI disclosures (1) to those family, friends and other persons involved in your treatment or payment, (2) that you otherwise requested in writing, (3) that you agreed to by signing an authorization form, or (4) that we are otherwise required or permitted to make by law. As before, your request must be made in writing to our Privacy Officer. The request should specify the time period, but please note that we are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. THE RIGHT TO RECEIVE NOTICE OF A BREACH. You have the right to receive written notice in the event we learn of any unauthorized acquisition, use or disclosure of your PHI that was not otherwise properly secured as required by HIPAA. We will notify you of the breach as soon as possible but no later than sixty (60) days after the breach has been discovered.

G. THE RIGHT TO FILE A COMPLAINT. You have the right to contact our Privacy Officer at any time if you have questions, comments or complaints about our privacy practices or if you believe we have violated your privacy rights. You also have the right to contact our Privacy Officer or the Department of Health and Human Services' Office for Civil Rights in Baltimore, Maryland regarding these privacy matters, particularly if you do not believe that we have been responsive to your concerns. We urge you to contact our Privacy Officer if you have any questions, comments or complaints, either in writing or by telephone. Please note that we will not take any action, or otherwise retaliate, against you in any way as a result of your communications to the Pharmacy or to the Department of Health and Human Services' Office for Civil Rights. As always, please feel free contact us. We look forward to serving you as a Patient.

H. YOUR RIGHT TO REVOKE AUTHORIZATION. Any other uses and disclosures not described in this Notice will be made only with your written authorization. Please note that you may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

FOR ALL OTHER RESTRICTION REQUESTS

Contact Red Rock Pharmacy at 450 South 900 East, Suite 150, SLC, UT 84102. All requests must include your full name, date of birth, address and plan identification number.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with Red Rock Pharmacy at 450 South 900 East, Suite 150, SLC, UT 84102 or with the Secretary of the United States Department of Health and Human Services.

All complaints must be submitted in writing. You will not be penalized in any way for filing a complaint. Changes to this Notice: We reserve the right to change our privacy practices. We reserve the right to make the revised Notice effective for PHI we already have about you as well as any information we receive in the future, as of the effective date of the revised Notice. Upon request to the Privacy Office, Red Rock Pharmacy will provide a revised Notice to you.

Effective Date: This Notice is effective as of June 1, 2013.

AGREEMENT FOR RED ROCK PHARMACY SERVICES

Face Sheet/Patient Information Sheet is attached: ☐ Yes ☐ No

Red Rock Pharmacy provides services including, but not limited to, medications, medical supplies, and special packaging. The following agreement must be completed, signed, and returned prior to service. Red Rock Pharmacy will bill all appropriate agencies/insurances when applicable. The patient or Responsible Party will be responsible for any co-payments and non-covered charges.

Patient Information *(please print)*

Facility Name: _____ Facility Number: _____

Patient Name: _____ ☐ Female ☐ Male Room #: _____

Date of Birth: _____ Social Security Number: _____

Allergies: _____ Diagnosis: _____

Primary Physician: _____ Phone: _____

Primary Prescription Insurance: _____ Phone: _____

Name on policy *(if not patient)*: _____ Relationship: _____

RxID Number: _____ Rx Group Number: _____

BIN Number: _____ PCN: _____

PLEASE ATTACH A COPY OF ALL PRESCRIPTION INSURANCE CARDS - BOTH FRONT AND BACK.

ALL CORRECT INSURANCE INFORMATION MUST BE PROVIDED OR RESPONSIBLE PARTY WILL BE BILLED FULL PRICE.

Responsible Party/Bill To Information *(this is where the bill will be sent)*

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Work/Cell Phone: _____

Guarantee of Payment

After billing all given insurance, Responsible Party agrees to pay all co-pays, over-the-counter medications or non covered charges.

I, the undersigned, authorize Red Rock Pharmacy access to the above-mentioned patient's medical records for proper medication assessment. I guarantee payment in full for services rendered to the above-mentioned patient. Payment is due in one installment upon receipt of the monthly statement.

Red Rock Pharmacy reserves the right at any time to discontinue service to the patient for any account with a past due balance. There is a $40 service fee for all returned checks. The account will be assessed a penalty of 1.5% (18% per annum) on any balance unpaid within 30 days. In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee up to 35% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees. Automatic Payments will be charged between the 10th-15th of each month.

I understand that medications will be automatically dispensed and delivered. I agree that should the patient be discharged from the community, it is my responsibility to notify Red Rock Pharmacy. If medication is delivered to the community after discharge and is not refused at the time of delivery, it cannot be returned for credit. I agree to be responsible for payment of these medications.

Responsible Party: _____ **Date:** _____

(Signer must be the same as the Responsible Party listed above)

CONVENIENT PAYMENT OPTIONS

Patient Name: _____

Facility Name: _____

Date of Birth: _____ Phone: _____

Email Address: _____

Red Rock Pharmacy will bill all applicable prescription insurance and send out a monthly itemized statement. After billing all appropriate agencies and insurances, we offer payment options for co-pays, over-the-counter medications, and non-covered charges.

PLEASE CHOOSE ONE OF THE PAYMENT OPTIONS LISTED BELOW:

☐ **OPTION 1 ONLINE PAYMENT**

Go to our website redrockrx.com and click "Pay Your Bill" at the top of the page.

☐ **OPTION 2 AUTO WITHDRAWAL FROM BANK ACCOUNT**

Fill out the form on the following page titled Authorization for Auto Withdrawal from Bank Account to set-up automatic payments from your checking or savings account.

☐ **OPTION 3 AUTO WITHDRAWAL FROM CREDIT CARD**

Send an email to: accounting@redrockrx.com or call 385.315.5770. We will contact you for your credit card information.

I authorize CD Pharmacy LLC dba Red Rock Pharmacy to charge my credit card on file monthly. This authorization will remain in effect until I cancel it. I may cancel this authorization any time by contacting Red Rock Pharmacy at 385.315.5770 or emailing accounting@redrockrx.com.

Name on Credit Card: _____

Signature of Card Holder: _____

Date: _____

☐ **OPTION 4 PAYMENT BY CHECK**

Send a check to Red Rock Pharmacy by the due date to the address listed on your statement.

AUTHORIZATION FOR AUTO WITHDRAWAL-BANK ACCOUNT

Patient Name: _____ **Date:** _____

Patient Account Number: _____

By signing this Authorization for Auto Withdrawal, I/we hereby authorize CD Pharmacy LLC DBA Red Rock Pharmacy to initiate debit entries via Automated Clearing House (ACH) from my/our bank account held at the depository financial institution named below. I/we hereby authorize CD Pharmacy LLC DBA Red Rock Pharmacy to debit the account monthly between the 10th and 15th of every month reflecting the monthly invoice due. ACH transactions will not occur on a Saturday, Sunday, or any national holiday recognized by the State of Utah. I/we acknowledge that the amount of all debits executed pursuant to this authorization may vary, but each debit shall equal the amount of the "due" amount per statement.

ACH INSTRUCTIONS:

Name of Bank: _____

Bank Address: _____

City _____ ST _____ Zip _____

Name on Account: _____

I hereby authorize Red Rock Pharmacy to initiate debit entries to my (select one): ☐ Checking Account ☐ Savings

Routing Number: _____ Account Number: _____

This Authorization is to remain in full force and effect until CD Pharmacy LLC DBA Red Rock Pharmacy has received written notification of its termination in such time and manner as to afford CD Pharmacy LLC DBA Red Rock Pharmacy and Depository a reasonable opportunity to act on such notification. I/we understand that if I/we fail to maintain sufficient credit balance in the account to complete the ACH transaction a 3.5% of the amount due will be charged to reprocess the transaction.

A voided check is required

Attach VOIDED Check Here:

I understand that the balance reported on my monthly statement will be automatically withdrawn from the account indicated above **on or around the 15th of each month**. I understand that this authorization will remain in effect until I notify Red Rock Pharmacy of any changes to my account information or cancellation requests at least 15 days prior to the next billing date. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the term indicated on this authorization form.

I / We release CD Pharmacy LLC DBA Red Rock Pharmacy and its affiliates, agents and representatives from all liability for their compliance with these instructions.

Name *(printed)*: _____ Date: _____

Authorized Signature: _____ Title: _____