# Patient Welcome Packet

ORLANDO HEALTH® | Scripts

# Welcome

Dear Valued Customer:

Welcome to Orlando Health Scripts pharmacy. We appreciate the opportunity to serve you for all your specialty pharmacy needs. We are committed to providing you with the quality care and exceptional customer service you deserve.

Our pharmacy team consists of pharmacists, pharmacy technicians, clinical specialists and patient care coordinators. We will work together with you, your physician and your insurance company to ensure you will have continued access to specialty medications for your complex treatment plan. We are dedicated to providing you with the personal service necessary to ensure the best possible outcomes for you.

Please take a few moments to review the important information in this welcome packet, which explains our services and answers some of the more common questions you may have.

To ensure your privacy as well as permission to bill your insurance company on your behalf, we have included some forms to be completed and returned to our pharmacy department via the enclosed self-addressed envelope. Patient forms are located in the back pocket. Please take a moment to complete and return to the pharmacy today.

If we can assist you with any questions about our services, please contact us at the customer service number below. We sincerely appreciate the opportunity to serve you and again, thank you for choosing Orlando Health Scripts pharmacy.

Sincerely,

Orlando Health Scripts pharmacy team

1111 Blackwood Ave.
Ocoee, FL 34761
(321) 842-1622

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ACCREDITED
Specialty Pharmacy
Expires 10/01/2024

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# WELCOME TO ORLANDO HEALTH SCRIPTS PHARMACY

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## Welcome Packet

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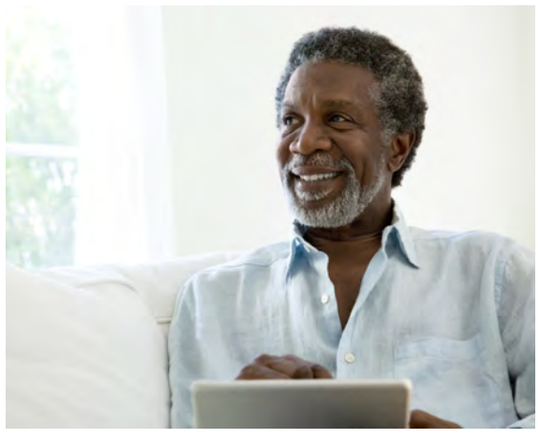
# INTRODUCTION TO SERVICES

## Getting Started

Once your provider sends a prescription to the specialty pharmacy, you will be automatically enrolled in our personalized Orlando Health Scripts patient management program, which is dedicated to improving your health through education and caring.

We offer:

- Personalized services specific to your condition
- Educational materials to help you better understand and manage your condition
- Monthly refill reminder calls to help you refill your medications on time
- Expertise to help you save time and money on your specialty medications
- Convenient, timely, confidential medication delivery options
- 24/7 access to specially trained pharmacists



This service is provided to you at no additional cost and enrollment is optional. You may contact us at any time to be removed from this service.

### Disclosure and Confidentiality Policy

Orlando Health Scripts pharmacy's top priority is protecting the confidentiality of the information you, your health plan and your healthcare providers share with us. We promise to use this information only to deliver the services your health plan has contracted with us to, and to provide you with helpful information.

### Pharmacist Assistance

Our clinical pharmacists are specially trained on the medication you are taking, and they are here to answer your questions about your care plan. Please call the specialty pharmacist if you have any questions regarding your treatment. A licensed pharmacist is available 24 hours a day, seven days a week, for any urgent needs relating to your medication. After normal business hours, please leave your contact information with our after-hours answering service, and the pharmacist on call will promptly return your call. In the case of an emergency, call 911.

### Patient Care Management Programs

Orlando Health Scripts pharmacy offers several comprehensive patient care management programs for specific medical conditions. Proactive and clinically based, these programs provide therapy-specific care to improve your health. The service includes continuous clinical evaluation, ongoing health monitoring, assessment of educational needs and management of medication use.

## Your Personalized Care Team

Orlando Health Scripts pharmacy offers personalized patient care, education on your condition and access to pharmacists that are available whenever you need to discuss your medication, symptoms, side effects and anything that may affect your health. We are here to help and support you and your doctor, so you receive the best possible care throughout your treatment.

# INTRODUCTION TO SERVICES

Your specialty pharmacy care team can also:

- Schedule a refill shipment
- Check the status of your order
- Answer billing or insurance questions
- Assist in obtaining prior authorizations
- Help find financial assistance

As advocates for your health, we are here to answer any questions you may have.

Contact us

- When you have any questions about your medication
- When you think you are having a side effect or allergic reaction
- When you stop or start any medication, even those filled at another pharmacy
- When your contact information or delivery address has changed
- When your insurance or payment information has changed
- When you need to check status of your delivery
- When you need to reschedule or change your delivery or have a concern about delivery delays
- When you have any other questions or concerns related to our pharmacy services

To reach your specialty pharmacy team, please call (321) 842-1622. In the case of an emergency, call 911. We are here to help. Whatever your question or concern, your call is important to us. We appreciate the opportunity to be your full-service specialty pharmacy throughout your therapy.

## Payment Policy

Before your care begins, Orlando Health Scripts pharmacy will inform you of your financial obligations that are not covered by your insurance. Upon request we will provide you with the cash price of the medication and any other financial information including network status of the pharmacy.

## Drug Claims

Orlando Health Scripts pharmacy will submit claims to your health insurance carrier on the date your prescription is filled. However, you may still have to pay a portion of the cost. Your out-of-pocket costs may include, but are not limited to: deductibles, copayments, coinsurance and annual out-of-pocket limits.

You will be responsible for paying your copayment when you order your medication or refills. We will tell you the exact amount you need to pay Orlando Health Scripts pharmacy. If the claim is rejected, our staff will notify you so we can work together to resolve the issue.

## Medical Insurance Claims

Orlando Health Scripts will bill Medicare Part B for you, when applicable. However, you may be responsible for paying a coinsurance and/or deductible amount. If your health plan denies coverage for your medications, or if you disagree with the benefits or coverage of your medications, you may have the right to appeal with your health plan.

## Payment Plan

If you need help in arranging a payment plan for an outstanding balance, or receive a check from your insurance company, please call our pharmacy department to speak with a patient care coordinator.

# INTRODUCTION TO SERVICES

## Financial Assistance

Our staff will present all financial assistance options available for you and assist you with the application process for programs, which include drug manufacturer assistance programs and coupons as well as foundations that provide funding for specialty medications.

## Pharmacy Contact Information

### Pharmacy Care Team

Main (321) 842-1622
Fax (321) 842-1629

### On-call Pharmacist

Available 24 hours a day/seven days a week to assist you with any urgent matters regarding your medication.
(321) 842-1622
ScriptsSP@OrlandoHealth.com

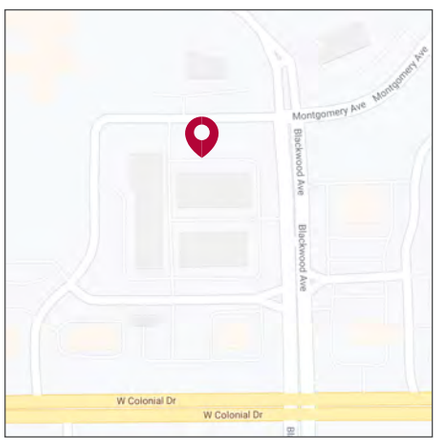
## Pharmacy Hours and Location

### Regular Business Hours

Monday – Friday, 9:00 am – 5:30 pm (Eastern Time)

### Business Location

1111 Blackwood Avenue, Ocoee, FL 34761




The Orlando Health Scripts specialty pharmacy will be closed on the following holidays:

- New Year's Day *(January 1)*
- Memorial Day *(last Monday in May)*
- Independence Day *(July 4)*
- Labor Day *(first Monday in September)*
- Thanksgiving *(fourth Thursday in November)*
- Christmas *(December 25)*

## Visit Us Online

OrlandoHealth.com/Scripts

# YOUR MEDICATION

## Obtaining Medications and Services

### How to Fill a New Prescription

Orlando Health Scripts pharmacy will work with your prescriber when you need a new prescription drug. Your prescriber can fax, telephone a new prescription or electronically prescribe to Orlando Health Scripts pharmacy. You may also call Orlando Health Scripts pharmacy and request that we contact your prescriber to obtain a new specialty prescription.

### Ordering Refills

A patient care coordinator will call you before your medication is scheduled to run out to check your progress, verify shipping address, confirm delivery date and connect you with a clinical pharmacist if you have any questions or concerns about your treatment. Please call (321) 842-1622 during our normal office hours if you have any questions, need assistance or need a refill before we contact you.

### From Your Pharmacist

The pharmacist is available for counseling on the medications provided to you at the number listed on the label of your medication. Written information about this prescription has been provided for you. Please read this information before you take the medication.

The pharmacy reports prescriptions for controlled substances to Prescription Monitoring Programs as required by state law. This information may be requested by specific individuals from state Prescription Drug Monitoring Programs for a limited number of purposes as authorized by state law.

# YOUR MEDICATION

### Delivery of Your Specialty Medications

We coordinate delivery of your specialty medications to your home, your prescriber's office or an approved alternate location. We also will include any necessary supplies, such as needles, syringes and alcohol swabs. If your medications require special handling or refrigeration, they will be packaged and shipped accordingly. If you cannot be there to accept the package, we can arrange for it to be left at your home or an approved alternate location. A signature may or may not be required for the delivery but is an available option for each shipment.

### Special Packaging and Shipping

Orlando Health Scripts pharmacy uses special packaging and expedited shipping. We do this because, under certain circumstances, a medication's effectiveness could be affected by exposure to extreme heat, cold or humidity. You also may notice a change in the number of ice packs used or if they're frozen or unfrozen — these factors may be changed based on the time of year. If the package looks damaged or is not in the correct temperature range, please call us.

### About Your Order

We value our customers and want to continue to provide excellent customer service. You can help us by verifying the accuracy of your shipments upon receipt. Please call our pharmacy care team to report any concern or discrepancies.

### Generic Substitution

Whenever possible, Orlando Health Scripts pharmacy will substitute a lower-cost generic medication for a brand-name medication unless you or your prescriber has asked for a specific brand-name drug. This may occur for new prescriptions, refills, therapeutic changes and prescription transfers.

### Side Effects

If you experience a medication side effect, please contact your physician or pharmacy care team for medical advice as soon as possible. If you need immediate medical attention, go to the nearest Emergency Department. In case of a life-threatening emergency, call 911.

### Adverse Drug Reactions

If you experience an adverse drug reaction or an allergic reaction, acute medical symptoms or other problems, please contact your physician for medical advice as soon as possible, visit your local emergency room or call 911 immediately.

# YOUR MEDICATION

### Returned Goods Policy

The State Board of Pharmacy Regulations forbids the resale or reuse of a prescription item that was previously dispensed. As a result, no credit can be issued for any unused or excess products. We will arrange a return and reshipment of medication if your medication or supplies are defective.

### Medications Not Available at Orlando Health Scripts Pharmacy

If you cannot obtain a medication at Orlando Health Scripts pharmacy, your pharmacy care team will work with you and another pharmacy to ensure you receive your medication. If you want your prescription transferred to another pharmacy, please contact the pharmacy, and we will transfer your prescription on your behalf.

### Medication Delays

In the event of an order delay, we will contact you to inform you about the delay and will provide assistance.

### Patient Concerns

If you have any comments or concerns about your medications, services received, delivery or other issues, please contact us. If you suspect any medication issue(s) related to errors or counterfeit medications, please call Orlando Health Scripts pharmacy, and we will address your concern within 24 hours or the next business day. We will be happy to assist you.

If you want to file a written complaint, please fill out the Patient Concern Form located in the back pocket with Additional Materials. We will address your concern within five business days and provide a final resolution (verbally or in writing) within 14 days.

If we are not able to help solve your concern, you may contact the Florida Department of Health by calling (850) 245-4339.

### Additional Information

For patients who are non-English speaking, translation services are provided. For more information, call (321) 842-1622.

# PATIENT MANAGEMENT PROGRAMS


## Patient Management Programs

- Orlando Health has created a model of care for patients with chronic and complex conditions. Our patient care teams are staffed by pharmacists, registered nurses, pharmacy technicians, patient care coordinators and reimbursement specialists each with therapy-specific training for a focused level of service.
- Our programs are customized to your individual needs; our therapy management program covers the spectrum of care from proactive monitoring of therapy to counseling you on effectively managing side effects.
- For new prescriptions, our specialty pharmacists offer to counsel each patient (or caregiver) by telephone, explaining the medication, its storage requirements, adverse effects, precautions, dosing parameters and instructions for use.
- Our care team will contact you or your designated caregiver prior to each new or refill shipment to arrange delivery, to monitor therapy outcomes and to encourage therapy adherence.
- We also will contact you throughout your therapy regimen to promote proper use of the medication and to help you manage any side effects you may experience.
- Orlando Health Scripts specialty pharmacy will deliver to your preferred location — home, office or clinic as appropriate for administration.

# PATIENT MANAGEMENT PROGRAMS

- Our specially trained clinicians are available by telephone 24 hours a day, seven days a week to help you manage critical aspects of your care, no matter what time of day questions arise.
- Orlando Health Scripts pharmacy care management programs are clinical programs that focus on adherence to drug therapy. The goal of each program is to increase the number of patients that will achieve the desired clinical result by improving patient compliance to the prescribed medication regimen.
- This service is provided to you at no additional cost, and your participation is completely voluntary. You can opt out at any time by calling, emailing or requesting in person to be removed from the patient management program.

## Patient Management Program Patient Rights and Responsibilities

- The right to know about philosophy and characteristics of the patient management program.
- The right to have personal health information shared with the patient management program only in accordance with state and federal law.
- The right to identify the staff member of the program and their job title, and to speak with a supervisor of the staff member if requested.
- The right to speak to a health professional.
- The right to receive information about the patient management program.
- The right to receive administrative information regarding changes in, or termination of, the patient management program.
- The right to decline participation, revoke consent or disenroll at any time.
- The responsibility to submit any forms that are necessary to participate in the program, to the extent required by law.
- The responsibility to give accurate clinical and contact information and to notify the patient management program of changes in this information.
- The responsibility to notify their treating provider of their participation in the patient management program, if applicable.

# PATIENT RIGHTS AND RESPONSIBILITIES

**Each Patient Has the Right To:**

- Be treated with dignity and respect without regard to race, color, creed, sex, age, national or ethnic origin, diagnosis or source of payment.
- Be provided with information regarding ownership, available services, insurance coverage and other charges if applicable.
- Be informed about his/her illness and treatment, when and how services will be provided, the name and function of any person and agency providing care and service, and the name of the person responsible for coordination of care.
- Be informed in advance about any changes in the care or treatment as it pertains to their well-being.
- Make informed decisions about his/her care and actively participate in the planning of care.
- Be instructed in his/her care therapy in order to reach the highest level of self-care and wellness and to have his/her healthcare preferences considered in the treatment of care.
- Continuity of care and service provided by personnel who are qualified through education and experience to perform the service for which they are responsible.
- Participate in experimental treatment and research with voluntary, informed consent documented.
- Refuse treatment, within the confines of the law, after being fully informed of and understanding the consequences of such action.
- Confidentiality and privacy in treatment and care, including confidential treatment of patient records; compliance with a request of disclosure of information; and refusal of their release to any outside individual, except in the case of transfer to another health facility, or as required by law or third-party contract.
- Be informed of any financial benefit when referred to an organization.
- Voice complaints and grievances and be informed of procedure for registering complaints without reprisal, coercion or unreasonable interruption of services.
- Receive prompt response to all reasonable interruption of services.
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated, and how to submit complaints and appeals.
- Choose a healthcare provider and be informed of provider services and care limitations.
- Have one's property and person treated with respect, consideration and recognition of client/patient dignity and individuality.

# PATIENT RIGHTS AND RESPONSIBILITIES

**Each Patient Is Responsible For:**

- Providing accurate and complete information regarding his/her medical history.
- Agreeing to a schedule of services and reporting any cancellation of scheduled services.
- Participating in the development and updating of a plan of care.
- Communicating whether he/she clearly understands the course of treatment and plan of care.
- Following the plan of care and clinical condition.
- Reporting problems, unexpected changes in physical condition, hospitalizations, concerns or complaints.
- Accepting responsibility for his/her actions if refusing treatment.
- Fulfilling financial obligations for services.
- Notifying the pharmacy of changes in address, telephone number or insurance.
- Maintaining patient equipment provided to them by the pharmacy, if applicable.

# PATIENT SAFETY INFORMATION

## Handwashing

One of the best ways to prevent the spread of germs and infections is to wash your hands. Always wash your hands before and after you prepare or handle your medications. Here are some tips from the Centers for Disease Control and Prevention (CDC).

- Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
- Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers and under your nails.
- Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse hands well under clean, running water.
- Dry hands using a clean towel or air dry them.

## Hand Sanitizers

Alcohol-based hand sanitizers can reduce the number of germs when soap and water are not available.

- Apply enough product on hands to cover all surfaces.
- Rub your hands together, until hands are dry.

# PATIENT SAFETY INFORMATION

## Home Safety

### Medication and Poisoning

Here are some recommendations from the CDC:

- Always keep an up-to-date list of all medications you take, including over-the-counter drugs such as vitamins, herbals and nutritional supplements.
- Read the label every time you take a dose to make sure you have the right drug and that you are following the instructions.
- Keep medicines in their original bottles or containers and out of reach of children. Use child-resistant packaging.
- If poison is suspected, call Poison Control at (800) 222-1222.

### Falling

Falls are the most common accidents in the home. Some medications can cause lightheadedness or dizziness, increasing the risk of falls. Here are some suggestions on how to reduce the chance of a serious injury:

- Arrange furniture to avoid obstacles.
- Add grab bars inside and outside your tub or shower and next to the toilet.
- Keep electrical and other cords out of walkways.
- Clean spills immediately.
- Make sure your home has good lighting. Use night lights as needed.

## How to Handle Medications Safely

### Proper Disposal of Sharps

If your therapy involves the use of needles, make sure to use a sharps container for proper disposal.

The following simple rules will help to ensure you and your family's safety during your therapy.

1. Never place the cap back on a used needle. Instead, place it immediately it the sharps container.
2. Always keep the sharps container out of reach of children and pets.
3. Containers should be no more than three-quarters full. Never overfill the container as you may be exposing yourself or a family member to a dirty needle stick. Report all needle stick or sharps-related injuries promptly to your physician.
4. As a backup if you don't have a sharps container available, you may use an empty laundry detergent bottle with a screw on lid for disposal of your sharp items.
5. Never dispose of sharp items in glass or a clear plastic container. Never put sharp items in a container that can be recycled or returned to a store.
6. You may dispose of your sharps container at your local fire department or your local health department. Many counties have a program to return sharp containers.

You can check the following website to learn more about safe needle disposal and locations in Florida.
https://safeneedledisposal.org/states/florida/

# PATIENT SAFETY INFORMATION

### Safe Disposal of Your Medications

For instructions on the proper disposal of unwanted or unused medications, check your local waste collection services. You can also check the following FDA website for additional information: www.fda.gov/forconsumers/consumerupdates/ucm101653.htm


### Follow These Simple Steps to Dispose of Medicines in the Household Trash

**Mix**

Mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, cat litter or used coffee grounds.

**Place**

Place the mixture in a container such as a sealed plastic bag.

**Throw**

Throw the container in your household trash.

**Scratch Out**

Scratch out all personal information on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable, then dispose of the container.

# EMERGENCY DISASTER INFORMATION

## Patient Information on Emergency Preparedness

In the event of an emergency, follow instructions from your local law enforcement, civil defense and emergency preparedness agency. You can find more helpful information about Emergency Preparedness at www.redcross.org.

### FIRE

- Rescue anyone from immediate danger. If bedridden: Tie a knot in the head and foot of the sheet.
- Using the sheet, pull the person to safety. If two people are available, make a chair with the rescuer's arms and carry the patient to safety.
- If safe, alert fire department. Otherwise, evacuate area.
- Turn off oxygen ($O_2$) (if applicable), and try to contain the fire by closing off any access such as doors.
- Attempt to extinguish the fire only if it is in a small localized area; otherwise, evacuate building and notify the fire department when you are safe.

### EARTHQUAKE

- In prone areas, store food and extra bottled water. Also have transistor radio, flashlights and batteries available. Report any special needs for backup generator to electric/gas company.
- Check for injuries.
- Check home for any gas or water leaks and turn off appropriate valves. Obtain a pipe wrench to shut off valves for gas and water.
- Evacuate area if necessary.
- Stay away from windows or broken glass. Wear shoes at all times.
- If evacuation is necessary, go to the nearest shelter, and notify the organizers of any special needs requests.

### HURRICANE/TORNADO

- Check for injuries.
- Check home for any gas or water leaks and turn off appropriate valves.
- Notify electric/gas company of any special needs for backup generator.
- Evacuate area if necessary.
- Stay away from windows or broken glass. Wear shoes at all times.
- If evacuation is necessary, go to the nearest shelter, and notify the organizers of any special needs requests.

### FLOOD

- Contact the local law enforcement, civil defense and/or emergency preparedness.
- In flood-prone areas, store extra food and extra bottled water. Also have transistor radio, flashlights and batteries available. Obtain a pipe wrench to shut off valves for gas and water. Report any special needs for backup generator to the electric/gas company.
- Evacuate the area.
- Contact the local law enforcement, civil defense and/or emergency preparedness.

# FREQUENTLY ASKED QUESTIONS

**Q. How is a specialty pharmacy different from a retail pharmacy?**

**A.** Specialty pharmacies are dedicated to ensuring the best possible outcome from your therapy. Some of the things we do include:

- Enrollment in a patient management program
- Contact you to ensure you have access to your medication without experiencing any gaps in therapy.
  – This includes delivery of the medication
  – Assisting with prior authorizations
  – Assisting with financial assistance
- Partnering with you and your provider to achieve therapy treatment goals through our patient management program.
- Provide you with a complete review of your medication that includes getting an accurate listing of your current prescriptions and screening for drug interactions and disease states.

**Q. How important is it to take all of my medications?**

**A.** Your chance of a better health outcome improves when you take your medications as prescribed. Carefully read all the directions on the prescription label and ask your pharmacist or prescriber if you have any questions. We understand that some medications may have unpleasant side effects or may be difficult to administer, that's why our team is here to offer practical advice on how to manage these situations.

**Q. How do I order a refill? Will you automatically send it to me?**

**A.** Orlando Health Scripts specialty pharmacy will not automatically send you the medication. A pharmacy technician will call you to schedule your delivery at least a week before your next refill. During this call, we will confirm that you are still taking the medication, that your prescriber has not changed the dose and that you are not having any unmanageable side effects. Please call us if you need your medication sooner.

**Q. How long does it take to receive my medications?**

**A.** Once your prescription is ready, our care team will contact you to coordinate a delivery date. Medications are usually shipped with expedited delivery within 24 to 48 hours.

**Q. What should I do if my order is delayed?**

**A.** Orlando Health Scripts specialty pharmacy will make every attempt to contact you if there is any delay with your medication delivery. However, if your delivery does not arrive by the end of the expected day, please contact us at (321) 842-1622. We can track the status of your delivery with a tracking number.

**Q. How do I access medications if an emergency or disaster occurs?**

**A.** During an emergency or disaster, our pharmacy will be available at (321) 842-1622 to provide pharmacy services. In the event that we cannot provide services from our location, we will coordinate with your health plan provider and other pharmacy providers to ensure you receive your medication.

**Q. What happens if there is a drug recall?**

**A.** Orlando Health Scripts pharmacy follows the drug recall guidelines created by the FDA, drug manufacturers, drug distributors and/or state and federal regulatory agencies. Our pharmacy will contact you and your prescriber in the event you are affected by a drug recall.

# FREQUENTLY ASKED QUESTIONS

**Q. What if I have questions about my medications?**

**A.** Please call (321) 842-1622 to speak to one of our pharmacists. If you are calling after normal business hours, please leave your contact information with our after-hours answering service. In case of an emergency, please call 911.

**Q. If I need copay assistance, how does this work?**

**A.** Depending on the copay assistance organization, you may be required to pay for a portion of the copay. Also, many organizations have a maximum amount they will pay on your behalf per year; if your copays exceed this limit, you may be responsible for the remaining balance. Orlando Health Scripts specialty pharmacy will handle the billing for you. We will charge your insurance first and then the copay assistance organization for your medication. The organization will pay the copay on your behalf. If you have been conditionally approved for copay assistance through the Chronic Disease Fund (CDF), The Assistance Fund (TAF) or the National Organization for Rare Disorders (NORD), you will be required to complete and return all paperwork and supporting documentation in a timely manner. Delays may put you at risk of losing your assistance.

**Q. What preparations do I need to be aware of while traveling in regard to my medication?**

**A.** At least two weeks prior to your departure, take an inventory of your medication at home. This should give you enough time to call the pharmacy and get another shipment delivered to your home if needed, as well as obtain any prescriptions from your doctor. If you expect to need an early refill before your trip, please call us at (321) 842-1622 so we can see if your insurance will provide a vacation override. Make sure to carry your medication with a copy of your prescription or the bottle/container with your prescription information on it and remember to pack your medication in a secure and easy-to-reach area of your carry-on luggage only.

**Q. What should I do if I am unable to reach Orlando Health Scripts specialty pharmacy, and I'm running out of medication?**

**A.** If at any time it is not possible for you to reach Orlando Health Scripts specialty pharmacy, and you are running out or are out of medication, please contact your prescribing physician for immediate instructions.

**Q. This welcome packet contains a lot of information. Which forms do I need to return?**

**A.**
- Orlando Health Scripts specialty pharmacy Service Agreement – Required
- Acknowledgement Form – Required
- Medicare Assignment of Benefits Form – Required only if we must bill Medicare Part B
- Authorization to Communicate Form – Optional
- Patient Satisfaction Survey – Optional
- Patient Concern Form – Optional

ORLANDO HEALTH®

## NOTICE OF PRIVACY PRACTICES

**Effective Date: April 14, 2003**
Revised June, 2006
Revised May, 2008
Revised May, 2013

**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.**

If you have any questions about this notice, please refer to our website, orlandohealth.com, or you may contact the Corporate Privacy Officer by telephone at 321.843.3333, email to informationsecurity@orlandohealth.com or mail: Orlando Health, MP 29, 1414 Kuhl Ave., Orlando, FL 32806.

**WHO WILL FOLLOW THIS NOTICE**
This notice describes Orlando Health's practices regarding the use and disclosure of your medical information, including use and disclosure by (a) any healthcare professional authorized to enter information into your medical record, (b) all departments and units of the system, (c) volunteers we allow to help you while you are in the facility, (d) all contracted services, and (e) all members of Orlando Health's workforce.

All Orlando Health entities, sites and locations follow the terms of this notice, including: all Orlando Health hospitals, South Lake Hospital and its affiliates, Health Central Hospital and its affiliates, Orlando Health Physician Group, Physician Associates LLC. , Health Central Park, Howard Phillips Center for Children & Families, Healthchoice, Orlando Health Foundation, Arnold Palmer Medical Center Foundation, home health services, ambulance services, outpatient centers, and all other Orlando Health sites and locations. Also included are staff and contracted physician services such as, but not limited to, emergency department physicians, pathologists, anesthesiologists, radiologists, hospitalists, physicians who interpret tests, and all other members of the medical staff when seeing patients in our facilities. These individuals, entities and facilities may share medical information with each other for treatment, payment or hospital operations purposes described in this notice.

**OUR PLEDGE REGARDING MEDICAL INFORMATION**
We understand that information about you and your health is personal. We are committed to protecting that medical information. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the records of your care generated by Orlando Health, whether made by our employees or your personal physician. Your personal physician may have different policies or notices regarding use and disclosure of medical information created in his/her office or clinic. This notice tells you about the ways in which we may use and disclose information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to: make sure that health-related information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; follow the terms of the notice that is currently in effect and notify you following a breach of unsecured protected health information.

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**
The following categories describe the ways that we use and disclose health-related information. For each category of use or disclosure, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

*For Treatment*
We may use and disclose your information to provide you with medical treatment and to coordinate or manage your health care and related services. For example, we may use and disclose information about you to physicians, nurses, technicians, medical students, family members, clergy, or others who are involved in your care. We may use and disclose medical information about you when you need prescription, lab work, X-rays or other healthcare services, or when referring you to another healthcare provider.

*For Payment*
We may use and disclose information about you so the treatment and services you receive can be billed to and payment may be collected from you, an insurance company or a third party. (For example, we may need to give your health plan information about surgery you received so your health plan will pay us or reimburse you for the surgery.) We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

*For Healthcare Operations*
We may use and disclose information about you for normal hospital operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. (For example, in the course of quality assurance and utilization review activities, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent physicians who are members of the medical staff but not Orlando Health employees.) We may disclose medical information to business associates who provide contracted services such as accounting, legal representation, claims processing, quality assurance, accreditation, and consulting. If we do disclose medical information to a business associate, we will do so subject to a contract that provides that the information will be kept confidential. We may also combine medical information about patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to physicians, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning who the specific patients are.

*Appointment Reminders*
We may use and disclose information to contact you as a reminder that you have an appointment for treatment.

*Follow-Up Phone Calls*
As part of your treatment plan, there may be times that you will be contacted by Orlando Health staff via telephone after you have had service at one of its facilities. Examples include: (1) a follow-up phone call after discharge from the hospital to answer any questions from the patient or family or to determine that the patient is recovering appropriately; (2) a phone call to address patient satisfaction issues; or (3) a phone call to provide additional education or guidance to the patient on a particular topic related to their hospital stay. Such phone calls will be limited in number and are meant to ensure optimum recovery, patient satisfaction and education.

*Treatment Alternatives and Health-Related Benefits and Services*
We may use and disclose information to recommend or tell you about treatment alternatives and health-related benefits or services that may be of interest to you.

*Hospital Directory*
We will include certain limited information about you in the hospital directory if you are assigned a bed in one of our hospitals. This information may include your name, location in the hospital, general condition (fair, good, etc.) and religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. (This does not apply to behavioral health patients.) Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. If you do not wish to have this information included in the hospital directory, notify registration personnel. (A request not to be included in the hospital directory must be made for each visit.)

*Individuals Involved in Your Care or Payment for Your Care*
Unless you object, we may release information about you to a friend or family member who is involved in or helps pay for your medical care. We may also tell your family or friends your general condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

*Research*
Under certain circumstances, we may use and disclose information about you for research purposes. (For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.) All research projects are subject to a special approval process that evaluates a proposed research project and its use of medical information, trying to balance the research needs with the patient's need for privacy of their medical information. Before we use or disclose information for research, the project will have been approved through this research approval process; however, we may disclose information about you to people preparing to conduct a research project to help them look for patients with specific medical needs, so long as the information they review does not leave Orlando Health. When our staff conducts a research project in which they look back at old medical records, your personal information will not be disclosed outside the hospital nor will you be identified in any reports. If a research project is conducted where your information cannot be held confidential, a separate process is in place for you to consent for this type of research.

*Service Excellence*
We may follow-up your visit with us by sending to the address listed in your records a brief written survey about your satisfaction with the level of service provided to you. In some cases, the survey may be conducted by telephone or e-mail using the contact information listed in your medical record. In some instances, your name may be passed on to members of the service excellence team to investigate a complaint or corroborate an incident.

*Fundraising*
We may use certain information (name, address, telephone number, dates of service, age, gender, treating physician, department where you received service, health insurance status, and outcome) to contact you in the future to raise money for Orlando Health. We may also provide this information to an institutionally-related foundation for the same purpose. The money raised will be used to expand and improve the services and programs we provide the community. You have the right to opt out of receiving such communications.

*As Required By Law*
We will disclose information about you when required to do so by federal, state or local law.

*To Prevent a Serious Threat to Health or Safety*
We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures would only be to someone able to help prevent the threat.

**SPECIAL SITUATIONS**
*Organ and Tissue Donation*
If you are an organ donor, we may release information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

*Military and Veterans*
If you are a member of the armed forces, we may release information about you as required by military authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

*Workers' Compensation*
We may release information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

*Public Health Risks*
We will disclose information about you for public health activities as required by law. These activities generally include the following: (a) to prevent or control disease, injury or disability; (b) to report births and deaths; (c) to report child abuse or neglect; (d) to report reactions to medications or problems with products; (e) to notify people of recalls of products they may be using; (f) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (g) to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence.

*Health Oversight Activities*
We will disclose information to a health oversight agency for activities authorized by law. These oversight activities include: audits, investigations, inspections, and licensure that are necessary for the government to monitor the healthcare system, government programs, and compliance with applicable laws.

*Lawsuits and Disputes*
If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if we are assured that reasonable efforts have been made to tell you about the request or to obtain an order protecting the information requested.

*Law Enforcement*
We may release information if asked to do so by a law enforcement official: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the patient agreement; (d) about a death we believe may be the result of criminal conduct; (e) about criminal conduct at the hospital; and (f) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

*Coroners, Medical Examiners and Funeral Directors*
We will release information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We will also release information to funeral directors as necessary to carry out their duties.

*National Security and Intelligence Activities*
We may release information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

*Protective Services for the President of the United States and Others*
We may disclose information about you to authorized Federal officials so they may conduct special investigations and provide protection to the President or other officials and dignitaries.

*Inmates*
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official to provide you with healthcare, to protect your and other's health and safety, or for the safety and security of the correctional institution.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**
You have the following rights regarding the medical information we maintain about you:

*Right to Inspect and Copy*
You have the right to inspect and obtain copies of medical information that may be used to make decisions about your care. (Usually, this includes medical and billing records but does not include psychotherapy notes.) To inspect and obtain a copy of medical information that may be used to make decisions about you, you must appear in person or submit your request in writing to: Orlando Health, Release of Information, MP 69, 1414 Kuhl Ave., Orlando, FL 32806. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, labor, electronic media or other supplies associated with your request. We may deny your request to inspect and obtain a copy of your medical information in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

*Right to Amend*
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Orlando Health.

To request an amendment, your request must be made in writing and submitted to Orlando Health, Health Information Management, MP 97, 1414 Kuhl Ave., Orlando, FL 32806. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the medical information kept by or for the hospital; (c) is not part of the information which you would be permitted to inspect and copy; or (d) is accurate and complete.

*Right to an Accounting of Disclosures*
You have the right to request an accounting (list) of certain types of disclosures we have made of medical information about you. We are not required to account for certain disclosures such as: (a) disclosures you authorize; (b) disclosures to carry out treatment, payment and healthcare operations; and (c) disclosures to persons involved in your care. To request an accounting of disclosures, you must submit your request in writing to: Orlando Health, Release of Information, MP 69, 1414 Kuhl Ave., Orlando, FL 32806. Your request must state a time period, which may not be longer than six years, and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. There may be a charge for additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

*Right to Request Restrictions*
You have the right to request a restriction or limitation on our use or disclosure of information about you for treatment, payment or healthcare operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. (For example, you could ask that we not use or disclose information about a surgery you had to a particular family member.) You may make this request orally to registration personnel and you will be designated as a "no publicity" for that episode of care. If you (or another person on your behalf) pays in full at the time of admission for a specific health care item or service, you have the right to request that information with respect to that item or service not be disclosed to your health plan for purposes of payment or health care operations, and we will honor that request unless the disclosure is otherwise required by law. For all other restrictions, you must complete the "Request for Restrictions on Uses and Disclosures of Protected Health Information" form available at any Orlando Health admission/registration center or from the Corporate Privacy Officer. You may contact the Corporate Privacy Officer at 321.843.3333 to request a form and one will be mailed to you. Completed forms must be mailed to Attn: Corporate Privacy Officer, Orlando Health, 1414 Kuhl Ave., MP 29, Orlando, FL 32806. We will reply to you within 60 days. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

*Right to Request Confidential Communications*
You have the right to request that we communicate with you in a certain way or at a certain location. (For example, you can ask that we only contact you at work or by mail.) If you want to request confidential communication, contact a Registration or Billing Office representative, Monday through Friday during regular business hours and/or during the registration process. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must include the address and/or telephone number where you want to be contacted.

*Right to a Paper Copy of This Notice*
You have the right to a paper copy of this notice any time. You may obtain a copy of this notice at our website, orlandohealth.com, or at any admission/registration center.

**CHANGES TO THIS NOTICE**
We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in various locations indicating the effective date. Revised copies of this notice will be provided upon request.

**COMPLAINTS**
If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the facility, contact Orlando Health, Attn: Corporate Privacy Officer, 1414 Kuhl Ave., MP 29, Orlando, FL 32806 or by telephone at 321.843.3333. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**OTHER USES OF MEDICAL INFORMATION**
Other uses and disclosures of information not covered by this notice or the laws that apply to us will be made only with your written permission. These include most uses and disclosures of psychotherapy notes, most uses and disclosures for marketing purposes and disclosures for which we receive remuneration in exchange for your information. If you provide us permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

5711-100757 E 5/16

## Patient Satisfaction Survey

Orlando Health Scripts pharmacy is committed to providing you with outstanding service and care. Please scan the QR code below, which will lead you to a survey. We appreciate your time and assistance. Your feedback is important to us.

ORLANDO HEALTH®

Scripts

P.O. Box 568624
Orlando, FL 32856

connect to health

OrlandoHealth.com/Scripts

# REGISTRATION FORMS

## Orlando Health Scripts Specialty Pharmacy Service Agreement

STATEMENT OF NONDISCRIMINATION. Orlando Health Scripts specialty pharmacy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (321) 841-7375 (TTY: (877) 955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (321) 841-7375.

In consideration of Orlando Health Scripts specialty pharmacy agreement to (i) provide me with my medications; and (ii) bill my insurance carrier or third-party payer that is obligated to pay for my medications, I agree to the following terms and conditions;

1. AUTHORIZATION FOR MEDICAL TREATMENT: I authorize Orlando Health Scripts specialty pharmacy, under the direction of my physician, to provide me with my medications. I have been instructed by my physician about my prescribed medications and understand the reasons why they are considered necessary as well as their risks, benefits, possible complications and alternatives. As in any medication therapy, I understand that there are unknown risks as well as known risks. I certify that no guarantee or promise, expressed or implied, has been made to me by Orlando Health Scripts specialty pharmacy in conjunction with the medications that have been prescribed for me.
2. NOTICE OF PRIVACY PRACTICES. By my signature below, I acknowledge that I have received today, or that I have previously received a copy of the Orlando Health Notice of Privacy Practices (NPP). I understand that Orlando Health reserves the right to revise the NPP at any time and that I may obtain a copy of the current NPP on request from any admission/registration center and at www.orlandohealth.com.
3. RELEASE OF PROTECTED HEALTH INFORMATION: By signing below, I hereby consent to Orlando Health Scripts specialty pharmacy and its business associates using and disclosing my Protected Health Information (PHI) for treatment and normal healthcare operations purposes. I also hereby consent to Orlando Health Scripts specialty pharmacy and its business associates using and disclosing my PHI for the purpose of securing payment for the medications provided to me, including, but not limited to, appealing a determination by any third-party payer. This consent will remain in effect until revoked. This consent is revocable upon written notice to Orlando Health Scripts specialty pharmacy, except to the extent that action has already been taken in reliance on it.
4. ASSIGNMENT OF BENEFITS: I hereby assign to Orlando Health Scripts specialty pharmacy all insurance benefits and payments to which I am entitled from all third-party payers that are obligated to pay for my medications, including Medicare and/or Medicaid if applicable, for any services, medications, equipment or supplies that are furnished to me by Orlando Health Scripts specialty pharmacy, and authorize Orlando Health Scripts specialty pharmacy to seek such insurance benefits and payments from all third-party payers that are obligated to pay for my medications directly, and that this assignment of benefits shall be ongoing and continuous, unless cancelled by me in writing. Cancellation of this assignment of benefits shall become effective when the cancellation is delivered to Orlando Health Scripts specialty pharmacy, my insurer(s) and each third-party payer that is obligated to pay for my medications. I request that payment of authorized Medicare benefits be made directly to Orlando Health Scripts specialty pharmacy on my behalf for any medications furnished to me by Orlando Health Scripts specialty pharmacy.

# REGISTRATION FORMS

5. FINANCIAL RESPONSIBILITY: I understand and agree that I am responsible for the payment of all sums that may become due for the medications provided to me by Orlando Health Scripts specialty pharmacy that are not paid by my insurer or other third-party payer for any reason, including, but not limited to, denial of coverage, exclusion from coverage, and/or absence of a responsible third-party payer. If, for any reason and to whatever extent, Orlando Health Scripts specialty pharmacy does not receive payment in full from my insurer or the third-party payer that is obligated to pay for my medications, I do hereby agree to pay Orlando Health Scripts specialty pharmacy directly for the unpaid balance, including but not limited to any copayments, deductibles, and coinsurance, within thirty (30) days of receipt of an invoice from Orlando Health Scripts specialty pharmacy. If my insurer and/or third-party payer that is obligated to pay for my medications issues payment directly to me, I agree to promptly endorse such payment to Orlando Health Scripts specialty pharmacy and forward it directly to Orlando Health Scripts specialty pharmacy on the day that I receive payment.
6. ENTIRE AGREEMENT: This agreement contains the entire agreement of the parties with respect to the matters addressed herein. No other representation, promise, or agreement, oral or otherwise, expressed or implied, not embodied herein, shall be of any force or effect. All amendments must be in writing and signed by both parties to have any effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors, heirs and assigns.

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**Please fill out, detach and mail required form to pharmacy.**

### Orlando Health Scripts Specialty Pharmacy Service Agreement

I have read, understand and agree to all the above. A photocopy of this agreement may be used as though it were an original. The Release of Protected Health Information and Assignment of Benefits will be effective until revoked by me in writing. Such revocation shall have a prospective effect only.

I HEREBY CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I HAVE RECEIVED A COPY THEREOF. I CERTIFY THAT I AM THE PATIENT, OR THAT I AM DULY AUTHORIZED AS THE PATIENT'S AGENT OR REPRESENTATIVE TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____

Please Print Patient Name

_____

Signature of Patient OR Patient's Agent/Representative  Relationship  Date

_____

Please Print Name of the Primary Insured

_____

Signature of the Primary Insured  Date

# REGISTRATION FORMS

## Orlando Health Scripts Specialty Pharmacy Acknowledgement

STATEMENT OF NONDISCRIMINATION. Orlando Health Scripts specialty pharmacy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (321) 841-7375 (TTY: (877) 955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (321) 841-7375.

In order to ensure effectiveness and the delivery of your Specialty Medication in the highest quality standard, Orlando Health Scripts specialty pharmacy uses special packaging and expedited shipping.

Your medication will be shipped at no charge to you. We use an overnight national courier or a same-day local courier depending on the nature of the delivery, location and predetermined guidelines.

We will coordinate with you the exact date of delivery and the approximate time. Most deliveries will require signature by the recipient. Please ensure that you are present to sign for and receive the package at its scheduled delivery location and time to avoid delay or compromising your medication.

In the event that you authorize your package to be delivered without a signature required, you acknowledge and agree that you are responsible for any lost, damaged or stolen packages.

In the event of a delivery delay, we will notify you of the reason for the delay. If a delay in a delivery results in interruption in your therapy, we will assist in facilitating a specialty medication fill from another pharmacy if applicable.

We value our customers and want to continue to provide excellent customer service. You can help us by verifying the accuracy of your shipments upon receipt. Please call your Orlando Health Scripts specialty pharmacy team to report any concerns or discrepancies.

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**Please fill out, detach and mail required form to pharmacy.**

### Orlando Health Scripts Specialty Pharmacy Acknowledgement

I have read, understand, and agree to the above.

I acknowledge that I have received and understand the Welcome Packet information including the Rights and Responsibilities

Print Name _____ Date _____

Signature _____

# REGISTRATION FORMS

## Medicare Assignment of Benefits Form (Medicare Part B Billing Only)

STATEMENT OF NONDISCRIMINATION. Orlando Health Scripts specialty pharmacy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (321) 841-7375 (TTY: (877) 955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (321) 841-7375.

As a requirement of participating in the Medicare program, Orlando Health Scripts specialty pharmacy is required to secure this Assignment of Benefits, Patient Certification, Authorization to Release Information, and Payment Request for each Medicare Beneficiary.

ASSIGNMENT OF BENEFITS: MEDICARE PART B LIFETIME AUTHORIZATION: I hereby assign to Orlando Health Scripts specialty pharmacy all insurance benefits and payments to which I am entitled from all third-party payers that are obligated to pay for my medications, including Medicare and/or Medicaid if applicable, for any services, medications, equipment or supplies that are furnished to me by Orlando Health Scripts specialty pharmacy, and authorize Orlando Health Scripts specialty pharmacy to seek such insurance benefits and payments from all third-party payers that are obligated to pay for my medications directly. This assignment of benefits shall be ongoing and continuous, unless and until canceled by me in writing. Cancellation of this assignment of benefits shall become effective when the cancellation is delivered to Orlando Health Scripts specialty pharmacy, my insurer(s) and each third-party payer that is obligated to pay for my medications. I request that payment of authorized Medicare benefits be made directly to Orlando Health Scripts specialty pharmacy on my behalf, for any medications furnished to me by Orlando Health Scripts specialty pharmacy. I certify that the information given by me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed to determine these benefits or benefits for related services. I understand that I am responsible for any applicable deductible and coinsurance and non-covered charges.

**Please fill out, detach and mail required form to pharmacy.**

### Medicare Assignment of Benefits Form (Medicare Part B Billing Only)

I HEREBY CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I HAVE RECEIVED A COPY THEREOF. I CERTIFY THAT I AM THE PATIENT, OR THAT I AM DULY AUTHORIZED AS THE PATIENT'S AGENT OR REPRESENTATIVE TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Beneficiary Name

HIC # Account #

Product(s) to be Supplied Start Date

Witness Time/Date

Patient Signature Time/Date

BY: Patient's Agent/Representative (if patient unable to sign) Time/Date

Print Name of Signature Above

# REGISTRATION FORMS

If signed by Agent/Representative, please answer A. and B. below:

A. Please identify relationship to Patient (check one):

- ☐ Legal Guardian
- ☐ Recipient of Social Security or other governmental benefits on behalf of Patient ("Representative Payee")
- ☐ Spouse, relative or other person who arranges for Patient's treatment or who exercises responsibility for Patient's affairs
- ☐ Representative of institution or agency that provides care/support/assistance to Patient

_____

Name of Institution/Agency

_____

Print Your Name and Position

B. Briefly explain the reason Patient is unable to sign: _____

_____

_____

If Patient is unable to sign, and no individual listed above can be located, an Orlando Health Scripts specialty pharmacy representative may sign after making reasonable efforts to locate and obtain a signature of one of the individuals specified above.

If signed by an Orlando Health Scripts specialty pharmacy representative, also complete C below:

C. (If signed by an Orlando Health Scripts specialty pharmacy representative) Explain efforts to locate individuals specified above:

_____

_____

_____

# ADDITIONAL MATERIALS

## Medicare Prescription Drug Coverage and Your Rights

### You have the right to get a written explanation from your Medicare drug plan if:

- Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

You **also have the right to ask** your Medicare drug plan **for an exception** if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;" or
- You believe you should get a drug you need at a lower cost-sharing amount.

### What you need to do:

- Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception if you believe you need a drug that is not on your drug plan's formulary or believe you should get a drug you need at a lower cost-sharing amount.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:

1. The prescription drug(s) that you believe you need.
2. The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.
3. The date you were told that the prescription drug(s) is not covered.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to distribute this information collection once it has been completed is one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

No. CMS-10147

# ADDITIONAL MATERIALS

## Authorization to Communicate Form

**AUTHORIZATION TO COMMUNICATE WITH FAMILY MEMBERS AND FRIENDS INVOLVED IN YOUR CARE - OUTPATIENT**
*AUTORIZACIÓN PARA COMUNICACIÓN CON FAMILIARES Y AMIGOS INVOLUCRADOS EN SU CUIDADO: AMBULATORIO*

I, _____ (print name) hereby authorize the Orlando Health outpatient department _____ (department name) staff to verbally disclose the minimum amount of protected health information necessary to individuals listed below who are directly involved in my care or payment of my care.

*Yo, _____ (escriba su nombre en letra de molde) por la presente autorizo al personal del departamento ambulatorio de _____ (nombre del departamento) de Orlando Health a divulgar verbalmente la cantidad mínima de información de salud protegida necesaria para los individuos nombrados a continuación que están directamente involucrados en mi cuidado o en el pago de mi cuidado.*

| | | | | |
|---|---|---|---|---|
| 1. _____ Name/*Nombre* (Please Print/*En letra de molde*) | | | _____ Relationship/*Relación* | |
| _____ Address/*Dirección* | City/*Ciudad* | State/*Estado* | _____ Phone Number/*Número de telefono* | |
| 2. _____ Name/*Nombre* (Please Print/*En letra de molde*) | | | _____ Relationship/*Relación* | |
| _____ Address/*Dirección* | City/*Ciudad* | State/*Estado* | _____ Phone Number/*Número de telefono* | |
| 3. _____ Name/*Nombre* (Please Print/*En letra de molde*) | | | _____ Relationship/*Relación* | |
| _____ Address/*Dirección* | City/*Ciudad* | State/*Estado* | _____ Phone Number/*Número de telefono* | |

Please indicate information you DO NOT want disclosed: (initial each selection)/*Indique la información que NO QUIERE que se divulgue: (ponga sus iniciales en cada sección)*

_____ HIV/AIDS *VIH/SIDA*

_____ Drug and/or Alcohol Abuse/*Abuso de sustancias y/o alcohol*

_____ Mental Health/*Salud mental*

_____ Genetic Counseling/Testing Information/*Información sobre asesoría o pruebas genéticas*

_____ Other (be specific)/*Otros (sea específico)* _____

- I understand that this authorization is effective starting on the date above and will expire in one year. / *Entiendo que esta autorización comienza a ser efectiva desde la fecha indicada anteriormente y que caducará en un año.*
- I understand that I may revoke (cancel) this authorization by written notice to the Outpatient Department listed above. / *Entiendo que puedo revocar (cancelar) esta autorización por medio de una notificación escrita al Centro ambulatorio nombrado anteriormente.*
- I understand that the cancellation will not apply to any information released before the cancellation date. / *Entiendo que la cancelación no se aplicará a la información que se haya divulgado con anterioridad a la fecha de cancelación.*
- I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. / *Entiendo que mi información de salud protegida que se use o que se divulgue bajo esta autorización podría estar sujeta a una nueva divulgación por parte del receptor y que la privacidad de mi información de salud protegida ya no podría estar protegida bajo la ley.*
- I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan or eligibility for benefits on the provision of this authorization. / *Además entiendo que Orlando Health no puede condicionar la prestación del tratamiento, el pago, la inscripción en el plan de salud o la elegibilidad para beneficios a la provisión de esta autorización.*
- I understand that I will receive a signed copy of this form. / *Entiendo que recibiré una copia firmada de este formulario.*

Patient Signature/*Firma del paciente* _____ Date/*Fecha* _____

Print Patient Name/*Nombre del paciente Escriba en letra de molde* _____

Witness Signature/*Firma del testigo*_____ Date/*Fecha* _____

# ADDITIONAL MATERIALS

## Medicare Notice of Appeals Your Rights

Enrollee's Name (optional):_____

Drug and Prescription Number (optional): _____

### Medicare Prescription Drug Coverage and Your Rights

### Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an** "**exception**" if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

### What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

*Form CMS -10147*

# ADDITIONAL MATERIALS

## Medicare Part D Notice of Appeals (Spanish)

Nombre del beneficiario (opcional): _____

Número de receta y de medicamento (opcional): _____

### La cobertura de Medicare de las recetas médicas y sus derechos

### Sus derechos si tiene Medicare

Usted **tiene el derecho de solicitar una determinación de cobertura** de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene **el derecho de solicitar una determinación de cobertura especial conocida como "excepción"** si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como "formulario".
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido (un copago más bajo).

### Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo.

Si desea más información, consulte los materiales del plan o llame al 1-800-MEDICARE.

*Formulario de CMS-10147-Spanish*

# ADDITIONAL MATERIALS

## Patient Concern Form

Orlando Health Scripts pharmacy strives to provide you with the highest level of customer service. We want to provide your therapy to your complete satisfaction. If you have any concerns about your medications or services, we want to hear from you. You may call Scripts pharmacy to speak with one of our pharmacists or if you wish to file a complaint, you may do so by completing this form and mailing it to Scripts pharmacy, 1111 Blackwood Avenue, Ocoee, FL 34761. If we are not able to help solve your concern, you may contact the Florida Department of Health by calling (850) 245-4339. You may also call the Accreditation Commission for Health Care (ACHC) toll-free at (855) 937-2242. We take all concerns very seriously and view them as opportunities to improve our services and will respond to your complaint within 5 business days.

Date _____

Patient name _____ Patient date of birth _____

Person completing form _____ Relationship to patient (if applicable) _____

Preferred contact number _____

Prescription number(s) _____ _____ _____

Description of problem

_____

_____

_____

Employee involved (if applicable) _____

_____

### Scripts Pharmacy Official Use Only

Action taken _____

_____

_____

_____

Date Acknowledged _____ Date of Response _____

# ADDITIONAL MATERIALS

## Specialty Pharmacy Patient Management Program


**What are the Health Benefits of enrolling in our Specialty Pharmacy Patient Management Program?**

Our program is customized to your individual needs and provides you with a better opportunity for a positive outcome.

**Health Benefits of Patient Management Program:**

- Learn more about side effects and how to manage them
- More education and awareness about your condition and medication
- Coordinating care with your healthcare providers
- Improved medication compliance
  - Dedicated team to help find financial assistance
  - Assistance with prior authorization
  - Monthly refill reminders to help fill your medication on time

**What are the Limitations of our Patient Management Program?**

This is where we need your help, so that we can provide you with the best possible care!

- You must be willing to actively participate in our program, including:
  - Responding to our calls
  - Providing updates or changes to your health condition, including side effects, allergies
  - Providing updates or changes to your therapy, including changes to your medications
- You need to be willing to take your medication on time and as instructed by your physician for it to work properly
- Inform of us of any changes in the ability to obtain your medication

**We are here to help, please don't hesitate to ask!**