**Patient Rights and Responsibilities**

All patients have the right to:

* Be fully informed in advance about service to be provided, as well as any modifications to the plan of care
* Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for service expected from third parties and any charges for which the patient will be responsible
* Receive information about the scope of services that the organization will provide and specific limitations on those services
* Participate in the development and periodic revision of the plan of care
* Refuse care or treatment after the consequences of refusing are fully presented
* Be informed of patient rights under state law to formulate an Advanced Directive, if applicable
* Have one’s property and person treated with respect, consideration, and recognition of patient dignity and

individuality

* Be able to identify visiting personnel (if applicable) through proper identification
* Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property
* Voice complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or service without restraint, interference, coercion, discrimination, or reprisal
* Have complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
* Confidentiality and privacy of all information contained in the patient record and of protected health information
* Be advised on Wellpartner’s policies and procedures regarding the disclosure of clinical records
* Choose a health care provider, including choosing an attending physician, if applicable
* Receive appropriate care without discrimination in accordance with physician orders, if applicable

* Be informed of any financial benefits when referred to an organization
* Be fully informed of one’s responsibilities
* Be protected by additional state, local and federal laws pertaining to patient safety and care
* Know about philosophy and characteristics of the patient management program
* Have personal health information shared with the patient management program in accordance with state and federal law
* Identify the staff member of the program and their job title, and to speak with a supervisor of the staff member if requested
* Receive information about the patient management program
* Receive administrative information regarding changes in or termination of the patient management program
* Decline participation, revoke consent or disenroll at any point in time

All patients have the responsibility to:

* Inform Wellpartner if there are any issues with the product, or if the product is lost or stolen
* Inform Wellpartner if the directions for taking the medication have changed, or if you are no longer taking the medication
* Inform Wellpartner of any changes to your insurance or provider
* Pay the applicable copays or coinsurance for which your insurance does not pay
* Submit any forms that are necessary to participate in the program, to the extent required by law
* Give accurate clinical and contact information and to notify Wellpartner of changes in this information
* Notify their treating provider of their participation in the patient management program, if applicable

**Product Recalls**

Wellpartner follows all FDA regulations regarding drug recalls. In the event of a recall, the affected product(s) are identified and removed from inventory to assure they are not sent to patients. If Wellpartner is aware that a recalled product was sent to patients, patients will be notified, and your provider may be notified as well. Please note that the FDA does not require pharmacies to contact patients for all recalls. A drug is sometimes recalled before it reaches patients. Other times, you may be notified by your provider, the drug manufacturer (e.g. by press release), or by the FDA. If you are concerned about drug recalls and you have internet access, you can sign up to receive recall notifications from the FDA via email at www.fda.gov, or you can call the FDA at 1-800-INFO-FDA.

**Any Questions or Concerns?**

If you have a complaint regarding our service or the product you have received, have not received your medication or supplies, or have any questions at all, please call us at 1-800-473-3516 or email us at customerservice@wellpartner.com. We will do our best to resolve the complaint within 14 business days. All complaints will be handled in a professional and confidential manner, and are reviewed quarterly by our Performance Improvement Committee. In the event your complaint is not resolved to your satisfaction, you may contact our accrediting organization ACHC at 1-919-785-1214 or the Oregon Board of Pharmacy at 1-971-673-0001.

# Contacting a Pharmacist

If you have a question or concern regarding your medication(s), our pharmacists are available Monday through Friday from 7:30 am to 5:00 pm Pacific Time by calling 1-800-473-3516. An on-call pharmacist is also available 24 hours a day, 7 days a week for emergencies.

# Filling Prescriptions

For new prescriptions, your provider can send the prescription to us using any of the following methods:

* Via electronic prescribing (eRx)
* By fax at 1-877-597-3070
* By phone at 1-800-473-3516

***Please note****: Prescriptions for Schedule II controlled substances must be mailed.*

Refills may be ordered through our website at www.wellpartner.com, by mail, or by phone at 1-800-473-3516. If you need assistance using the website, please call us.

Because there may be delays if we need to contact your provider or insurance plan regarding your order, please allow up to 7 to 10 days to receive new prescriptions. Most refills can be expected in 4 to 7 days. If you have any questions regarding your current order, please call us or email us at orderstatus@wellpartner.com.

Wellpartner will substitute FDA-approved generic medications when available. If you prefer to receive the brand name for a medication, please have your provider write the prescription for the brand name medication and note “dispense as written” on the prescription. Note that requesting brand name products may dramatically affect your co-pay; check with your insurance provider.

If we are unable to fill your prescription, are unable to fill it within a reasonable timeframe, or are unable to bill your insurance, we will contact you as quickly as possible to discuss your options. We may be able to transfer the prescription to another pharmacy that can better serve your needs. We will then send your prescription

to the other pharmacy so there is nothing more for you to do

In the event of an emergency or disaster that prevents us from filling your prescription(s) in a timely manner, a message will be placed on our website at www.wellpartner.com. We will also notify patients by phone or email of the emergency and advise them to fill their prescriptions elsewhere. Patients will be contacted once the emergency situation has been resolved.

# Health Information

Wellpartner provides information about common medical conditions, diagnoses and treatment options on our website. Just visit www.wellpartner.com, click “Wellpartner Online Pharmacy” at the very top of the page, and then the “Health Center” tab. In addition, your first order comes with patient education material with

information regarding your medical condition and links for patient support groups.

# Billing

Wellpartner will obtain your insurance information when you register so that we can properly bill your prescriptions, if applicable. If your insurance plan requires any additional steps to be taken (e.g. obtaining a prior authorization or getting additional documentation from your prescriber) prior to billing the prescription, we will contact your prescriber or plan to resolve the issue.

The amount you are billed will be determined by your insurance plan, and will depend on your co-pay and any applicable deductible. Generally, you are expected to be familiar with the co-pays for the prescriptions that you order, but we will call you before shipping your order if the cost is over $200. When your order is shipped, you will receive an automated phone call or email to let you know the cost of the order.

If your insurance information changes, please contact us as soon as possible so we can update your account. If you do not know if your existing prescription coverage is active, or if you have any questions at all regarding your benefits, please call your insurance plan. Wellpartner will assist with insurance questions and issues whenever we can, but we do not have direct access to your benefits information and you will get the most up-to-date information by calling your plan directly.

If you are unable to pay the co-pay remaining after your insurance is billed, or you do not have insurance, please call us to discuss your options with one of our billing agents. There are numerous patient assistance programs, rebates and coupons available for which you may be eligible. If you have internet access, we recommend visiting the website www.needymeds.org for a list of many of these resources. If you do not have internet access, you can call NeedyMeds at 1-978-281-6666.

# Use, Handling, Storage, and Disposal of Medications

Included with each prescription is a patient information sheet that outlines the proper use of the medication, possible drug interactions and side effects, and proper storage. Please note that since some medications can interact with other prescription or over-the-counter (OTC) medications, it is very important that you let your prescriber and Wellpartner know about any other medications, herbal products or dietary supplements that you are taking to ensure all of the products that you are taking are appropriate If you experience any of the listed side effects or believe you may be having an adverse reaction to a medication, either call 911 (if an emergency), your prescriber or call Wellpartner immediately to speak with a pharmacist.

Follow the included instructions regarding storage of the medication(s). Medications requiring refrigeration will be shipped using a next day delivery courier in most cases, in a cold pack to

ensure they arrive under the proper storage conditions. You will receive a call prior to shipment to ensure someone will be there to accept delivery. If you receive such a medication and it is warm to the touch or you suspect it was not properly refrigerated during shipment, do not use the product until you speak with a pharmacist. The pharmacist will determine whether the medication is still safe to use or if it should be discarded.

If you discontinue a medication and do not plan to resume taking it, or need to dispose of a medication for any other reason, please dispose of it properly using the following recommendations:

* Check with your local recycling center or police department for information about “drug take back” programs in your area.

These programs are becoming more common across the country.

* The Federal Food and Drug Administration (FDA) has information about the safe disposal of medications available at their website at www.fda.gov/ForConsumers/Consumer Updates/ucm101653.htm.
* If you do not have internet access, for most oral drugs, the FDA recommends that you combine the drug(s) with a foul-tasting substance such as cat litter or used coffee grounds, then seal the mixture in a plastic bag and throw it in your household trash.
* For some drugs, such as narcotic pain relievers (e.g. Oxycontin, Percocet, or Fentanyl) the FDA instead recommends flushing them down the toilet to prevent children or pets from retrieving them from the trash, as these medications can be extremely harmful or fatal to children or pets.
* Injectable drugs require special handling to prevent the syringe or needle used to inject the medication from accidentally poking another person. Many areas require these products to be disposed of in an approved Sharps container, which may need to be taken to a hazardous waste facility. If you have internet access, the website www.bd.com has a state-by-state guide with directions on how to safely dispose of these products. If you do not have internet access, you can call your local health department, or if you do not have their number, call us and we will give you specific instructions for your area.

# NEW PATIENT REGISTRATION

|  |  |
| --- | --- |
| **PATIENT INFORMATION** |  |
| NAME | DOB | GENDER  MALE  FEMALE |
| PHONE # | ALTERNATE PHONE # | E-MAIL |  |
| SHIPPING ADDRESS (STREET) | SHIPPING ADDRESS (CITY, STATE, ZIP) |  |
| PHYSICAL ADDRESS, IF DIFFERENT FROM ABOVE (STREET) | PHYSICAL ADDRESS (CITY, STATE, ZIP) |  |
| NAME OF GUARDIAN OR LEGAL REPRESENTATIVE (IF APPLICABLE) | RELATIONSHIP |  |
| PLEASE LIST ANY MEDICATIONS TO WHICH YOU HAVE KNOWN ALLERGIES |  |
| PLEASE LIST ANY MEDICAL CONDITIONS |  |
| PLEASE LIST ANY MEDICATIONS OR HERBAL OR DIETARY SUPPLEMENTS THAT YOU ARE CURRENTLY TAKINGDRUG NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STRENGTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FREQUENCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

If you wish for someone else to be able to speak with us regarding your prescription(s) and/or health condition(s), please complete the enclosed form titled "Member Authorization Allowing the Disclosure of Protected Health Information."

|  |
| --- |
| **INSURANCE INFORMATION** |
| PRIMARY INSURANCE COMPANY NAME | PRIMARY CARDHOLDER NAME | INSURANCE PHONE # |
| BIN | GROUP (AKA GRP OR RX GROUP) | PCN | RELATIONSHIP TO CARDHOLDER  SELF  SPOUSE/PARTNER  CHILD/DEPENDENT |
| SECONDARY INSURANCE COMPANY NAME | PRIMARY CARDHOLDER NAME FOR SECONDARY INSURANCE | INSURANCE PHONE # |
| BIN | GROUP (AKA GRP OR RX GROUP) | PCN | RELATIONSHIP TO CARDHOLDER  SELF  SPOUSE/PARTNER  CHILD/DEPENDENT |

I acknowledge that I have received and read a copy of the CMS DMEPOS supplier standards, an explanation of my rights and responsibilities as a patient and the Notice of Privacy Practices, which explains how my protected health information may be used and disclosed by Wellpartner. My signature below gives Wellpartner, Inc. my permission to obtain the relevant medical records or protected health information necessary to receive payment for my medications and/or supplies, and to directly bill my insurance plan(s) for these products. I understand that if I have any questions, concerns, or complaints, I can call Wellpartner at 1-800-8153539 to speak with a customer service representative.

Check this box if you consent to allow Wellpartner to obtain co-pay savings cards on your behalf to lower your co-pays.

|  |  |
| --- | --- |
| SIGNATURE | DATE |
| SIGNATURE OF GUARDIAN OR LEGAL REPRESENTATIVE (IF APPLICABLE) | DATE |

**MEMBER AUTHORIZATION ALLOWING THE DISCLOSURE OF PROTECTED HEALTH INFORMATION**

 Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that Wellpartner creates and maintains certain medical / prescription records in connection with the provision of services I receive through Wellpartner and/or my health plan. By signing this Authorization, I am permitting Wellpartner to disclose my protected health information to the authorized third-party identified below and/or allow such authorized third-party to act on my behalf. My protected health information may include medical records, prescription records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any other personal, medical or financial information held by Wellpartner and related to Wellpartner’s provision of services. Authorization to act on my behalf as the case may be shall be limited to the management of my Wellpartner account and healthcare records held by Wellpartner.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of Patient’s protected health information may apply. I understand and agree that such information will be disclosed if I place my initials in the space next to the type of information to be included with the disclosure:

 \_\_\_\_\_ HIV/AIDS test results and related records \_\_\_\_\_ Mental health information

 \_\_\_\_\_ Drug/alcohol treatment or referral information \_\_\_\_\_ Genetic testing information

Patient hereby authorizes Wellpartner to disclose his/her protected health information to the following individual or organization (the “authorized third-party”).

 Authorized Third-Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

This Authorization shall apply only to the named Patient and authorized third-party as follows:

Limited records release (authorization is for one occurrence and disclosure is limited to Patient’s healthcare records available when this request is processed by Wellpartner)

General records release (authorization shall remain effective for one year from the date of execution and disclosure is limited to providing Patient’s healthcare records to authorized third-party)

**Ongoing healthcare management (authorization shall remain effective for five years from the date of execution of this release and authorized third-party is hereby permitted, without restriction, to manage Patient’s Wellpartner account and related healthcare information maintained by Wellpartner)**

 Other Duration: \_\_\_\_\_\_\_\_\_\_ Other Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

**This Authorization may be revoked by the Patient at any time upon written notice to Wellpartner**

Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose. Patient understands that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, federal or state law may still restrict the re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Patient understands that he/she has the right to refuse to sign this Authorization and refusal to sign this Authorization will not affect enrollment in a health plan or eligibility for health benefits.

Patient understands that he/she has the right to revoke this Authorization in writing at any time by sending written notice to the address below. If Patient revokes this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization; however, any use or disclosure of Patient’s protected health information prior to such revocation is acknowledged by Patient as being properly authorized.

I have reviewed and I understand this Authorization and hereby agree to the terms set forth herein.

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient)

 **OR**

|  |
| --- |
|  By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Patient’s representative)  Relationship to Patient: Parent Legal guardian\* Holder of Power of Attorney\*  \*If signing as a Patient’s legal guardian, Holder of Power of Attorney, or other authorized representative then appropriate proof of such status must be provided with this Authorization.   |

**ALL FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID. PATIENT SHOULD RETAIN A COPY OF THE COMPLETED FORM FOR HIS/HER RECORDS.**

Send the signed Authorization or revocation of Authorization to Wellpartner as follows:

Wellpartner, Inc

Attn: Specialty

P. O. Box 5909

Portland, OR 97228-5909

**CMS Medicare DMEPOS Supplier Standards**

1. All Medicare DMEPOS suppliers must be in compliance with these Supplier Standards in order to obtain and retain their billing privileges. A supplier must disclose these standards to all customers/patients who are Medicare beneficiaries (standard 16). This is an abbreviated list. The full list can be found in 42 CFR sec. 424.57(c).
2. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
3. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
4. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
5. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
6. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
7. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
8. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
9. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier’s compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
10. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
11. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier’s place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
12. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician’s oral order unless an exception applies.
13. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
14. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
15. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
16. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
17. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
18. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
19. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
20. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
21. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
22. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
23. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). *Implementation Date: October 1, 2009*
24. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
25. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
26. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
27. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date: May 4, 2009*
28. A supplier must obtain oxygen from a state-licensed oxygen supplier.
29. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
30. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
31. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.