MATRX PHARMACY
1030 Avenue D, Suite 2, Snohomish, WA 98290
(P)360-863-3009 (F)360-217-7570 www.matrxltc.com

☐ **ROUTINE MEDICATION SERVICE**

☐ **EMERGENCY FILL ONLY**

New Patient Information

Patient Name:_____ Gender: M F DOB: ____/____/____

Community/Agency:_____ Social Security Number: _____

Prescription Insurance Information (attach card copy) ☐ Medicare ☐ Medicaid ☐ Other

Insurance Name	Contract NumberBin (ID #)	BIN#	PCN#	RX Group #

Allergies: _____

Medical Conditions: _____

Responsible Party for Billing Information

Name:_____ Relationship: _____

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

Phone Number (not facility): _____ Email: _____

I agree that I am responsible for all pharmacy charges for the above resident which are not covered by private insurance or Medicaid. I agree to pay statement balances on receipt unless other arrangements are made. Late payments of 30 days or longer will bear interest at rate of 12% per annum.

I agree to allow staff at the facility to act as my agent in both ordering and receiving medications.

I acknowledge that I have received a copy of the notice of privacy practices.

I request that my prescriptions be packaged in standard containers **without** child resistant safety caps.

_____ _____

Signature Date

A credit card or voided check is **required**, and will be charged if no payment(s) or arrangement(s) for payment have been made for charges 30 days past due. **FOR AUTOMATIC PAYMENT PLEASE COMPLETE ATTACHED FORM.**

Form of Payment: ☐ ACH **(Please provide a voided check)**

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card: _____ Card Number: _____ Expiration: _____

Signature:_____ Date: _____

AUTHORIZATION FOR AUTOMATIC MONTHLY PAYMENT

(Please Choose One Option Below)

☐ DIRECT PAYMENT VIA ACH (ACH DEBIT)

CONSUMER AUTHORIZATION FOR DIRECT PAYMENT VIA ACH (ACH DEBITS)

Direct Payment via ACH is the transfer of funds from a consumer bank account for the purpose of making a payment.

I (we) authorize **MATRX PHARMACY, LLC** ("COMPANY") to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits[1]) as follows:

☐ **Checking Account** / ☐ **Savings Account (select one)** at the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

DEPOSITORY NAME: _____

ROUTING NUMBER: _____ ACCOUNT NUMBER: _____

☐ DIRECT PAYMENT VIA CREDIT/DEBIT CARD

CONSUMER AUTHORIZATION FOR DIRECT PAYMENT VIA CREDIT OR DEBIT CARD

NAME ON CARD: _____

CARD NUMBER: _____

EXPIRATION DATE: _____ BILLING ZIP CODE: _____

I (we) understand that this authorization will remain in full force and effect until I (we) notify **MATRX PHARMACY, LLC** in writing that I (we) wish to revoke this authorization. I (we) understand that **MATRX PHARMACY, LLC** requires at least 30 days prior notice in order to cancel this authorization.[2]

PATIENT Name: _____ PATIENT Facility: _____

PRINTED Name: _____ Email (for receipt): _____

SIGNATURE: _____ Date: _____

[1] *The NACHA Operating Rules* do not require the consumer's express authorization to initiate Reversing Entries to correct erroneous transactions. However, Originators should consider obtaining express authorization of debits or credits to correct errors.

[2] Written debit authorizations must provide that the Receiver may revoke the authorization only by notifying the Originator in the time and manner stated in the authorization. The reference to notification should be filled with a statement of the time and manner that notification must be given in order to provide company a reasonable opportunity to act on it (e.g., "In writing by mail to 1030 Avenue D, Suite 2, Snohomish WA 98290 that is received at least three (3) days prior to the proposed effective date of the termination of authorization").

Matrx Pharmacy, LLC
1030 Avenue D, Suite 2
Snohomish, WA 98290
360-863-3009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

DATE OF NOTICE: 6/1/2013

Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as 'Protected Health Information'). We are also required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information and to abide by the terms of this notice, as it may be updated from time to time.

SECTION A: Uses and Disclosures of Protected Health Information

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes. We may obtain information to dispense prescriptions and for the documentation of pertinent information in your records that may assist us in managing your medication therapy or your overall health.

For treatment purposes, such use and disclosure will take place in providing, coordinating, or managing healthcare and its related services by one or more of your providers, such as when your pharmacist consults with your physician or a specialist regarding your medications, treatment, or condition.

For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing pharmaceutical care services, such as when your case is reviewed to ensure that appropriate care was rendered. For reimbursement purposes, your Protected Health Information may be disclosed to one or several intermediaries employed by your plan sponsor including but not limited to insurers, pharmacy benefits managers, claims administrators, and computer switching companies.

For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement, provider review and training, underwriting activities, reviews and compliance activities; planning, development, management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care that you were provided.

We store some of your Protected Health Information in electronic computer files. We backup our electronic records daily and employ other precautions to safeguard the integrity of your Protected Health Information. In spite of these precautions it is possible but unlikely that a computer crash or other technological failure could cause the loss of data. In addition, reasonable safeguards are employed to protect your Protected Health Information stored on electronic media.

We may use and disclose your Protected Health Information, without your authorization when the pharmacy needs to contact a physician or physician's staff and is permitted or required to do so without individual written authorization. We may use and disclose your Protected Health Information if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them.
From time to time, we may employ the services of business associates who may assist us in one or more tasks and who may use, change, or create Protected Health Information. Business associates are required to comply with all the privacy regulations on your behalf.

We may disclose Protected Health Information about you without your authorization to comply with workers compensation laws, as required by law enforcement, legal proceedings, public health requirements, health oversight activities, and as required by law.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us as described in Section B.

You may ask us to restrict uses and disclosures of your Protected Health Information to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members,

relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request.

You have the right to request the following with respect to your Protected Health Information: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of the disclosures of this information by us (we are not required to account to you for disclosures made for treatment, payment, operations, disclosures to you, disclosures to your care givers, for notifications or as otherwise excluded by law); and (iv) the right to receive a paper copy of this notice upon request. We may require you to pay for this request to cover our costs of copying, labor, and postage.

In addition, you may request, and we must accommodate the request, if reasonable, to receive communications of Protected Health Information by alternative means or at alternative locations. To make this request, please contact in writing:

Janet Kusler, RPh, Owner, Privacy Officer
1030 Avenue D, Suite 2
Snohomish, WA 98290

We may use your name to reference your prescriptions and pharmaceutical care services. You may be required to sign a signature log form to acknowledge receipt of service, to acknowledge receipt of this notice and the disclosure of Protected Health Information as outlined herein. We may disclose this information to other persons who ask for you or your prescriptions by name. You may restrict or prohibit these uses and disclosures by notifying a pharmacy representative orally or in writing of your restriction or prohibition. We are not required to honor those requests. We are able to provide treatment services to you even if you object to sign the acknowledgment of the receipt of this notice or if we decide not to honor a request regarding the information in this document. In the event of an emergency or your incapacity, we will do in our reasonable judgment what is consistent with your known preference, and what we determine to be in your best interest. We will inform you of any such uses or disclosures if uses and disclosures would require your signed authorization under such circumstances and give you an opportunity to object as soon as practicable.

We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, Protected Health Information that is directly relevant to the person’s involvement with your care or payment related to your care. In addition, we may use or disclose the Protected health Information to notify, identify, or locate a member of your family, your personal representative, another person responsible for care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you object to this use or disclosure, we will do in our judgment what is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person’s involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pickup filled prescriptions, or other similar forms of Protected Health Information.

We reserve the right to change the terms of this notice and to make new notice provisions effective for all Protected Health Information we maintain. You may receive a copy of this notice by contacting us as outlined in Section B or upon the receipt of pharmacy care services.

If you believe that your privacy rights have been violated, you may complain to us at the location described in Section B or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

SECTION B: Contacting Us

You may contact us for further information at:
Matrx Pharmacy
Janet Kusler, RPh, Owner, Privacy Officer
1030 Avenue D, Suite 2
Snohomish, WA 98290