Important Forms to Review, Complete, and Return

Dear Patient:

Thank you for taking the time to review the information contained within the 21st Century Specialty Pharmacy Welcome Packet.

To helps us provide you with the best care possible, we ask that you review the important forms attached to this letter. A copy of these forms is also found within the Welcome Packet. We ask that you:

- Carefully review each form.
- If you have any questions about any of the forms please contact us at the number below.
- Complete each form as indicated.
- Sign and date forms as indicated.
- Return the forms in the pre-paid envelope to 21st Century Specialty Pharmacy.

If you have any questions, please call us at 1-844-334-9615 or visit us online at www.21centurypharmacy.com. Thank you!

Sincerely,

The 21st Century Specialty Pharmacy Team

9605 57TH Ave.
Corona, NY 11368
844-334-9615 toll-free phone
844-941-4111 toll-free fax

Client / Patient Satisfaction Survey

Thank you for being a valued client of 21st Century Specialty Pharmacy. We request that you complete the following survey to assist us in the improvement of treatment, care, and services. Thank you.

Name: (Optional) _____ **Date of Birth:** (optional) _____ **Date:** _____

Name of Pharmacy Staff, (if known): _____

Please rate the following questions on a scale from 1 to 5, where **1**=Strongly Disagree, **2**=Somewhat Disagree, **3**=Neutral (no opinion), **4**=Somewhat Agree, and **5**=Strongly Agree:

Satisfaction Survey Question	Rating (1-5)
1. My initial contact with 21st Century Specialty Pharmacy staff was positive.	
2. The staff was courteous and professional.	
3. The staff was knowledgeable regarding my disease state and medication(s).	
4. My medications were filled accurately.	
5. My medications were filled in a timely manner.	
6. I was clearly educated regarding medication safety storage, administration, and disposal.	
7. The welcome package material was clear and useful.	
8. The staff was able to answer all questions concerning my medication(s) and/or therapy to my satisfaction.	
9. The pharmacy worked with my physician and insurance to provide coordination of care that met my needs.	
10. I understand my individual plan of care/treatment plan.	
11. My overall experience with 21 Century Specialty Pharmacy has exceeded my expectations.	

Comment/Suggestions:

_____

_____

Please return your completed survey in the postage paid envelope provided and/or mail your completed survey to: 21st Century Specialty Pharmacy, 9605 57TH Ave. Corona, NY 11368.

Thank you for your feedback to help 21st Century Specialty Pharmacy's efforts for continuous improvement in it's strive for excellence!

Acknowledgement of Welcome Packet Information

Acknowledgment of Clinical Program Admissions and Welcome Packet that contains the following information:

- **Pharmacy Mission and Vision Statement**
- **Pharmacy Contact Information & 24 Hour Support**
- **Hours of Operation**
- **Refills for Delivery to Client/Healthcare provider**
- **Information on Deliveries and shipping**
- **Financial Responsibility**
- **Assignment of Benefits including co-pay, insurance**
- **Shipping**
- **Counseling/Education**
- **Returns**
- **Emergency Situations**
- **Home Safety**
- **Medication and Medication Safety**
- **Disposal of Medical Waste**
- **Clinical Management Program Options**
- **Notice of Client Rights and Responsibilities\Clinical Management Program Patient Rights**
- **Nursing Service Information**
- **DME Standards**
- **Privacy Notice & Practices**
- **Customer Satisfaction Form**
- **Complaint Process**
- **Authorization for Release of Information Pursuant To HIPAA, (separate form from Welcome Packet).**

Please sign and return this acknowledgment with additional forms in the postage paid envelope provided.

Thank you!

I have received the 21st Century Specialty Pharmacy Welcome Package/Handbook and Release of Information.

Client Signature _____ Date _____

Print Name: _____

Address _____City_____ State _____Zip Code _____

RELEASE OF INFORMATION

Please complete and return the attached "AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA" form. Thank you!

Financial Responsibility and Assignment of Benefits

21st Century Specialty Pharmacy agrees to bill Medicare, Medicaid or a private insurance carrier for any pharmaceuticals dispensed. Should it be required by any program that the client is responsible for any deductible, co-insurance, co-payment or disallowance of payment, 21st Century Specialty Pharmacy Inc. has the right to bill the client of those charges and will provide accurate as possible estimate of the charges billed to the payer of those, if any which will be billed to the client. Further notification is provided that the cost(s) of services may have to be negotiated with your insurance company after delivery is made and that a good will estimate can be provided upon request. I, at this moment authorize 21st Century Specialty Pharmacy to request any medical records or copy of such that may be needed to ensure

I agree that the insurance company's verification of benefits does not release me from financial responsibility for services rendered. If the insurance company denies any claims, in part or whole, I am financially responsible for all charges not covered by my insurance. I understand that the insurance claims as subject to medical review and that the insurance company is not obligated to pay for services not covered by the applicable policy. I understand that this notification of benefits is a good faith estimate and that actual client financial responsibility will be determined when the claim is processed.

Payment Authorization: I request that payment of authorized Medicare benefits be made on my behalf to 21st Century Specialty Pharmacy for any services furnished me by 21st Century Specialty Pharmacy Corp. I authorize any holder of medical information to release information about me to the Health Care Financing Administration and its agents and information needed to determine these benefits.

I agree to inform 21st Century Specialty Pharmacy Corp. of any change in my status including, but not limited to; change in address, hospital or nursing home admissions and discharges, and any changes that affect my insurance coverage and payments or my ability to pay for products and services rendered by 21st Century Specialty Pharmacy moreover, prescribed by my physician. If you have any questions regarding this form, please contact 21st Century Specialty Pharmacy.

Client/Representative Signature _____ Date: _____

Print Client/Representative Name _____ Relationship _____

Clinical Management Program Options

21st Century Specialty Pharmacy has trained clinicians to assist the client his/her specialized needs, providing free consultations and communicating with other members of their healthcare team. During initial contact the staff will conduct a disease-specific initial assessment and based on the finding the clinician develops an individualized disease-specific Plan of Care based on evidence-based standards. The Plan of Care has interventions and measurable goals concerning the identified strengths and needs of the clients.

The staff conducts an ongoing reassessment of the client to identify changes in client or need for service, treatment or care and the plan of care update as warranted or at least every three months.

The clinical management of the disease is based on evidence-based standards of care and best practice optimizing client outcomes.

I choose the following option:

_____Elect to enroll in the Clinical Management Program, I am aware that may dis-enroll/opt-out at any time by notifying the staff.

_____I do not wish participate in the Clinical Management Program at this time, but am aware I have the choice to enroll at any time

_____I wish to unregister from the Clinical Management Program

Client Signature _____ Date _____

___ Verbal Consent Given

___ Written Consent Given

Staff Signature _____ Date _____

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**