Patient Handbook

IMPORTANT INFORMATION

Deliveries
Notice of privacy practices
Patient rights/responsibilities
Complaint procedures
Returns/refunds
Safety information
Weather emergency information
Equipment warranty information
Safe handling and storage of medications
Troubleshooting your infusion
IMPORTANT FORMS
Information Checklist
Medication Profile

IN CASE OF AN EMERGENCY DIAL 911

UCRx UNIVERSAL COMPOUNDING PHARMACY MARINER

KEY CONTACTS

Doctor's Name: _____ Phone# _____

Your physician has ordered the following Hospice Home Care services:

Team Member: **Phone No.**

Nurse Care Manager: _____

Social Worker: _____

Physical Therapist: _____

Occupational Therapist: _____

Speech Therapist: _____

Home Health Aide: _____

Dietician: _____

Other: _____

Equipment Company: _____

Pharmacy: **Northern California MARINER ADVANCED PHARMACY (MAPRx)**
345 Convention Way, Suite C | Redwood City, CA 94063
P (888) 999-0991 | F (888) 395-9798 | www.marinerpharmacy.com
PHARMCISTS ON-CALL: (650) 863-5468 (TEXT OK)

Southern California: UNIVERSAL COMPOUNDING PHARMACY (UCRx)
2895 Temple Ave | Signal Hill, CA 90755
P (888) 999-0991 | F (844) 888-0765 | www.ucrxspecialty.com
PHARMCISTS ON-CALL: (650) 863-5468 (TEXT OK)

PROVIDERS: FAX REFERRALS, ORDERS AND LABS
(888) 395-9798

SECURED EMAIL: ORDER@UCRXSPECIALTY.COM

PATIENT INFORMATION GUIDE

To all Clients:

MAPRx & UCRx team thank you and to your family for partnering with us to provide you with your pharmaceutical needs.

Our administrative and clinical staff will be working with you and your healthcare team to set a plan of care that will meet your needs. Please feel free to contact our office to discuss any concerns you or your family may have regarding the services(s) being provided to you.

Our Team is pleased to offer any counseling that you may need concerning your medications, supplies, and deliveries' that you may be receiving from our pharmacies along with any questions about drug interactions and reactions. We are dedicated to promoting quality service with integrity and excellence to our patients.

Deliveries

If you are receiving your treatment at home, you will be placed on a standard schedule by our pharmacy staff based upon your doctor's orders and your needs. However, if you believe that you will run out of supplies before your next scheduled delivery, please contact our office 4 days prior to your last supply has run out.

Each week our pharmacy will all to verify orders and make any changes if needed. If you are hospitalized or discontinuing therapy, please call Pharmacy in a timely matter with this information so that our staff can handle the situation accordingly.

Returns and Refunds

In order to protect our patients from contaminations, We cannot and will not take back any disposable supplies or medications once delivered to your home per state law. Only the prescribed quantity of supplies will be delivered or shipped to your home. Please contact our office for detailed instructions on how to dispose your used and unused supplies. No credits will be given for unused items once they are in the home.

Patient Rights

Every Patient's rights include, but are not limited, to the following:

1. To have access to services regardless of ability to pay, sex, religion, race, or belief in compliance with federal and state laws and Pharmacy policies and procedures.
2. To be treated with respect and dignity.
3. To be assured confidentiality in treatment and records.
4. To approve and/or refuse release of information to any outside vendor, unless being transferred to another facility or company or as required by law or third party payment contract.
5. To have access to the physician coordinating your care.
6. The right to view information regarding your diagnosis and treatment.
7. To be educated on the Pharmacy procedure for receiving, reviewing, and resolving your complaints.
8. To obtain a thorough and clear explanation of the total invoice for services rendered and products supplied to you.
9. To receive care in a timely and appropriate manner to suit your needs.
10. To obtain care free of abuse: I.E. mental, physical, or emotional.
11. To have your personal property, home, and space respected.
12. To have knowledgeable and competent healthcare professionals provide your care.
13. To declare who is authorized to make medical decisions on your behalf in the case you cannot do so yourself.
14. To decline treatment and supplies, as permitted by law, and be knowledgeable of the health risk of such refusal.
15. To partake in the plan of care of your choice, including but not limited to: discharge planning, treatment, and services.
16. To be educated on the type of care you will be provided, who will administer the prescribed services, who will oversee the services and the contact information for all healthcare providers along with the frequency and quantity of visits, unit charges, and to be informed orally and written as soon as any changes are made in your treatment of care no longer than 30 working days from the date the agency becomes aware of the change.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The pharmacy is required to maintain the privacy of your protected health information (PHI) and to provide you with a notice of our legal duties and privacy practices with respect to PHI. PHI is information about you, including basic demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your PHI to carry out treatment, payment or healthcare operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to your PHI.

This pharmacy is required to follow the terms of this Notice. We will not disclose your PHI without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for PHI we maintain. Upon request, we will have provided a revised Notice to you.

Health Information Rights:

You have the following rights with respect to your PHI:

Obtain a paper copy of the Notice upon request. You may request a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. To obtain a paper copy, contact the "Privacy Office" whose name appears at the end of this Notice.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the "Privacy Officer" whose name appears at the end of this Notice. We are not required to agree to those restrictions.

Inspect and obtain a copy of your PHI. You have the right to access and copy your PHI contained in a designated record set for as long as the pharmacy maintains the PHI. The "designated record set" usually will include prescription and billing records. To inspect or copy your PHI, you must send a written request to the "Privacy Officer" whose name appears at the end of this Notice. We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to fulfill your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that your PHI is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to the "Privacy Officer" whose name appears at

the end of this Notice. You must include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of your PHI after April 14, 2003 for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorized, disclosures to friends or family members involved in your care, and disclosures for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to the "Privacy Officer" whose name appears at the end of this Notice.

Your request must specify the time period, but may not be longer than six years. The first accounting you request within a 12-month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or alternate locations. For instance, you may request that we contact you about medial matters only in writing or at different residence or post office box. To request confidential communication of your PHI, you must submit your request in writing to the "Privacy Office" whose name appears at the end of this Notice.

Examples of how we may use and disclose PHI

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment.
We will use PHI for payment.
We will use PHI for healthcare operations.
We are likely to disclose PHI for the following purposes:

Business Associates: There are some services provided by us through contracts with business associates. Examples include our software system vendor and technology provider. When these services are contracted for, we may disclose your PHI to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. To protect your PHI, we require the business associates to appropriately safeguard the PHI.

Communication with individuals involved in your care or payment for your care: Health professionals such as pharmacists, using their professional's judgement, may disclose to a family member, other relative, close personal friend or any person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Health related communications: We may contact you to provide refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administrations: We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse

events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.

Worker's Compensation: We may disclose your PHI as authorized by and as necessary to comply with laws relating to worker's compensation or similar programs established by law.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose your PHI for law enforcement purposes as required by law or in response to valid subpoena or other legal process.

As required by law: We must disclose your PHI when required to do so by law.

Health oversight activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

We are permitted to use or disclose your PHI for the following purposes:

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, medical examiners, and funeral directors: We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to carry out their duties.
Organ or tissue procurement organizations: Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transportation of organs for the purpose of tissue donation and transplant.
Fundraising: We may contact you as part of a fundraising effort.
Notification: We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
Correctional Institution: If you are or becoming an inmate of a correctional institution, we may disclose your PHI to the institution or its agents when necessary for your health or the health and safety of others.
To avert a serious threat to health or safety: We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and veterans: If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.
National security and intelligence activities: We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective services for the President and others: We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
Victims of abuse, neglect or domestic violence: We may disclose your PHI to a government authority, such as a social services or protection agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other uses and disclosures of PHI:
The pharmacy will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

For more information or to report a problem:
If you have any questions or would like additional information about the pharmacy's privacy practice, you may contact the “Privacy Officer” whose name appears at the end of this Notice at the pharmacy address and telephone number at the bottom of the Notice. If you believe your privacy rights have been violated, you can file a complaint with the “Privacy Officer” whose name appears at the end of this Notice, or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Gold Stallion, Inc
Compliance Privacy Officer:
2895 Temple Ave
Signal Hill, CA 90755

Patient Responsibilities

Every patient has responsibility which include, but are not limited to the following:

1. To provide, to the best his/her knowledge, accurate and complete information about present medications and health conditions.
2. To inform Pharmacy of any changes in conditions to the appropriate healthcare staff.
3. To follow treatment plan exactly as ordered by your physician.
4. To make sure all appointments are kept and if for any reason your appointment cannot be kept, contact Pharmacy
5. To call immediately if Pharmacy employee does not show at scheduled time.
6. To verify all Pharmacy employees before letting them in the home by checking their ID badge and looking at the logo on their company polo.
7. To at all times respect all Pharmacy healthcare professionals regardless of race, sex, orientation, creed, and/or age.
8. To respect all Pharmacy equipment and property.
9. To fulfill all monetary obligations to Pharmacy in a timely matter.

Complaint/Grievance Procedure

At any time if you feel you are not receiving adequate care, you may express your concerns to Pharmacyby the way of written letter, email, or via phone.

Address:	**Phone:**
Gold Stallion, Inc 2895 Temple Ave Signal Hill, CA 90755\ Attn: Dr. Henry Truong, PharmD	Toll Free: (888) 999-0991 Local: (650) 579-5678 Fax: (888) 395-9798 Email: info@marinerpharmacy.com

And if for any reason you feel Pharmacyhas not handled your issue the way you see fit, you may contact your local health department or health regulation agency. You may also wish to contact our local health department and regulation agency.

Address:	**Phone:**
California Board of Pharmacy	Local: (916) 574-7900 Fax: (916) 574-8618

And if for any reason you feel Pharmacy and/or the local health department has not handled your issue the way you see fit, you may contact our accrediting organization.

ADVANCED DIRECTIVES

"Advanced Directives" relates to the right of individuals to make decisions prior to illness regarding type of care they would wish to receive as discussed in the Patient Self-Determination Act enacted by Congress as part of the Omnibus Reconciliation Act of 1990.

Advanced directives include:

1. Living Will Declaration: allows you to state in advanced life sustaining measures you are to receive should you become terminally ill or in a permanently unconscious state.
2. Durable Power of Attorney for Health Care: allows you to select someone to make health decisions for them if you lose the capacity to competently make decisions for yourself. Any adult of sound minds my voluntarily create a valid durable power of attorney for healthcare.

HOME SAFETY

Here are safety tips for using your medical equipment and supplies as well as for fall preventions, fire safety and preventing infection. Below, you will also find great safety tips to keep in mind while receiving any type of healthcare services.

At Mariner Advanced Pharmacy, we always keep your safety in our mind.

SAFETY CHECKLIST

Read your patient education information.
Ask your supplier questions about your equipment/supplies and take notes.
Keep *Instructions for Use* available at all times.
Do not connect equipment that requires electricity to extension cords or a multiple outlet strip.
Always read and follow the instructions as given.
Take care of your equipment/supplies according to the manufacturer's instructions (for such things as cleaning, replacing batteries, protection from harm, etc.).
Have emergency phone numbers for contacting your supplier, manufacturer and your doctor(s) readily available.
Always have a back-up plan and supplies.
Educate your family and caregivers about your medical equipment/supplies.
Keep children and pets away from your equipment/supplies.
Never overextend yourself while using your medical equipment. It's okay to ask for assistance if you need it.
Report any equipment malfunctions to your supplier immediately.
Keep your supplies and equipment clean and dry at all times.

FALL PREVENTION & HOME SAFETY

One of the top ten causes of death in the United States includes injuries sustained from individuals falling. Learning how to prevent falls will benefit people of all ages, so we are providing you with the following tips to increase your fall prevention awareness.

Begin a regular (and reasonable) exercise program. Exercise will help you to feel stronger, will improve your balance, and will decrease your chances of falling. Consult with your doctor prior to starting an exercise program.

Make your home safe. You can do this by:

Never placing items, you could trip over by stairs or in areas where you typically walk.

Installing grab bars in your bathroom.
Using non-slip mats in your bathtub or shower.
Improving lighting in your home.
Wearing shoes that give good support and have non-slip soles.

Review your medications with your healthcare provider(s). Some medications can make you drowsy or light-headed, which can lead to a fall.

Have your vision checked. Poor vision can increase your chances of falling.

Source: Centers for Disease & Prevention (CDC) fall prevention brochure, for more information, contact the National Center for Injury Prevention and Control, at www.cdc.gov/injury

Preparing for Weather Emergencies

Pharmacy wants all of our customers to be prepared for any weather emergencies such as hurricanes, floods, earthquakes or tornados that may interrupt your medication delivery. We pay close attention to the weather in our state and encourage you to do the same.

In case of any weather emergencies such as hurricanes that may affect the ability of Pharmacy to operate safely, the company offices may close for one or more days. When we have a pending hurricane or other weather emergency that may affect our ability to provide your regular shipment, we expedite the shipment of your order prior to the weather emergency and then transfer services to an alternative pharmacy location. If you anticipate being effected by a hurricane or other weather emergency that may interrupt your regular delivery, please contact our office at 1-888 and ask our pharmacy team to expedite your delivery.

If you relocate either temporarily or permanently as a result of a weather emergency, please provide us with your new address as soon as possible so that we may ship your medication and supplies to the correct location.

If our offices are closed due to a weather emergency, our answering service will still receive calls and the pharmacists at our alternate pharmacy site will respond to your inquiries. Once the weather emergency has passed, the company will re-open and resume normal operations.

In the event that you are unexpectedly affected by a weather emergency and need emergency replacement of supplies, please contact us via our toll-free number 1 (888) and we will ship replacement supplies to you.

We are Pharmacy appreciate your continued support and sincerely hope that you have a safe and uneventful storm season!

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a 1- year manufacturer's warranty. Pharmacy notifies all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law.

Pharmacy will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

RIGHT TO RENT OR PURCHASE FOR MEDICARE BENEFICIARIES

I understand that I have the right to rent or purchase items that Medicare considers inexpensive or routinely purchased durable medical equipment. I have been notified that Pharmacy does not provide inexpensive durable medical equipment. Durable medical equipment that is considered a capped rental (e.g.: infusion Pumps) will be rented for the period approved by Medicare and the title of such equipment will transfer to the beneficiary upon completion of the capped rental period. After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required service or repair.

Medicare General Information

CMS MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This list is an abbreviated version of the application certification standards that every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. pt. 424, sec 424.57(c) and are effective on December 11, 2000. A supplier, such as Mariner Advanced Pharmacy Corp, must disclose these standards to all customers/patients who are Medicare beneficiaries (standard 16).

1. 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.
2. 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.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. 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.
5. 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.
6. 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.
7. 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 or business. The location must be at least 200 square feet and contain space for storing records.
8. 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.
9. A supplier must maintain 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.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the suppliers' place of business, all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. 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.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. 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.
15. 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.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.

17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. 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
19. 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.
20. 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.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All supplies 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*
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date – May 4, 2009.*
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

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 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:

- The prescription drug(s) that you believe you need.
- The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.
- 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 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 Blvd., Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

HOME PATIENTS RECEIVING AND STORING OF MEDICATION AND SUPPLIES

Your medication and other therapy related supplies are provided by Pharmacy A delivery schedule will be coordinated with you by the pharmacy staff. Please make sure to check all supplies against the delivery ticket included with each delivery.

Check the medication label for: Your name, physicians name, proper drug, dosage and expiration date.

DO NOT infuse any solutions after the expiration date printed on the label. Before each infusion check all solutions before administering the medication. Check to make sure the medication vial or bag has no leaks and that there is no settling and/or particles in the solutions.

Your therapy requires the use of several medical supplies. Your home care nurse or aide will train you, your family, or care taker in the proper use of the supplies. If you are unsure about the supplies delivered or think something is missing, call the pharmacy at 1 (888)

MEDICATION STORAGE

It is important that medications are stored correctly when delivered. Check the medication labels for proper storage instructions.

If your medication is stored in the refrigerator, it should be removed 1-2 hours prior to usage and brought to room temperature.

STORAGE SUPPLIES

- Set aside a small workspace away from small children and pets.
- Supplies should never touch the floor.
- The red sharps container should only be used for needles, syringes, and other sharp objects related to your therapy.
- Store supplies in a dry place at room temperature and arrange in a neat and organized manner, this will help when inventorying your supplies.
- Check each package for breakage and tears in the safety coating. If breaks or tears are found you need to contact Pharmacyor your nurse immediately. Do not use as it is no longer sterile.
- Keep paper products dry. If they get wet, they are no longer sterile and should be thrown out immediately.

Please keep an inventory of your supplies so that you always maintain an adequate supply. If you are using more than normal amount of supplies and are running low, please call the pharmacy before you run out. We will ship you the necessary quantity as quickly as possible.

Please keep track of your supplies. Contact the pharmacy before you run out to ensure that you can continue your scheduled therapy.

ROOM SET UP

- The room should be neat and organized.
- Set aside a work area that is unused and away from small children and pets.
- Designate a specific time for your therapy so that you are free from interruptions.
- The work area should have a smooth flat surface that can be cleaned with alcohol or soap and water.
- The work area should be well lit at all times.
- Your sharps container should be accessible and within arm's reach.

SAFE HANDLING/DISPOSAL OF BIOMEDICAL WASTE

Place all needles, syringes, and sharp objects into the red "sharps container" that was provided to you.
Place all unused medical supplies into the sharps container if they have come into contact with blood or body fluids.
Any unused medical supplies or empty bags can be thrown in the trash ***ONLY IF THEY HAVE NO COME INTO CONTACT WITH BLOOD OR BODY FLUID.***
Never put your hand in the sharps container.
Do not place the cap in the sharps container until it is ¾ of the way full. Once the cap is placed on the container, it cannot be reopened.
Call Pharmacy for a new container when the container is half full.
Do not throw full sharps container into the trash. Pharmacy will instruct you on proper disposal methods.

WHAT IS ASPETIC (STERILE) TECHNIQUE?

Sterile or Aseptic Technique is a special method of handling objects to keep them from free of germs. If a sterile product is not handled properly, it becomes contaminated or "non-sterile." All producers sent to you from the pharmacy are already sterile. If you have any question or doubt any items sterility, PLAY IT SAFE.

WHEN IN DOUBT, THROW IT OUT!!!

PRINCIPLES OF STERILE TECHNIQUE FOR INFUSION THERAPY:

WASH YOUR HANDS before handling any sterile products.
DO NOT USE ANY EXPIRED SOLUTIONS OR MEDICATIONS!
DO NOT let the outside of a package touch the item inside.
DO NOT touch any sterile item with your fingers or let supplies touch any non-sterile surfaces. Use alcohol swabs or pads to disinfect injection caps or port sites where IV tubing is to be attached. (NEVER RETOUCH THE DISINFECTED AREA)

The sterile technique should be used when starting or stopping your infusion, changing your dressing, flushing your catheter, preparing your infusion, and changing your injection cap and tubing.

Hand Washing

Equipment:

- Antibacterial liquid soap
- Warm Water
- Paper Towels

Procedure:

Wash your hands thoroughly before and after you touch your IV site, or change a dressing, and at the direction of your nurse.

1. Prepare a clean sink area.
2. Remove all jewelry on hands, wrists and arms.
3. Turn on the water to lukewarm and wet hands, wrists and arms.
4. Apply a small amount of liquid soap to hands, wrists and arms.
5. Use a brisk motion back and forth to clean your hands for approximately 30 seconds.
6. Use friction to clean each fingers including your finger nails, palms, back of the hands, and two to three inches above the wrist.
7. Rinse hands thoroughly with lukewarm water.
8. Dry hands using a clean paper towel.
9. Turn off the faucet with the paper towel.
10. Do not use hand lotion.

CLIENT INFORMATION CHECKLIST

Please complete this form and return it to *within 10 days*. A self-addressed, postage-paid envelope is included in this package for your convenience.

Client Name	Date of Birth

Please check the boxes next to each item below acknowledging that you received and have read the noted documents provided by Pharmacy

- ☐ Customer Information, Customer Complaints, Customer Rights and Responsibilities *(See Separate Insert)*
- ☐ HIPAA Privacy Notice *(See Separate Insert)*
- ☐ Medicare Supplier Standards *(See Separate Insert)*

Please read the following statements and acknowledge by checking YES

YES **Acceptance of Services**

I understand that by signing this agreement, I authorize provision of products and/or services to me by Pharmacy I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

YES **Same or Similar Equipment or Supplies**

If "No" is checked, I acknowledge that I have never received the same or similar equipment or supplies, as listed above, from another home medical equipment provider. If I have selected "Yes", then I understand that my insurance carrier may not cover the above named supplies or equipment and I may be asked to execute an Advance Beneficiary Notice.

YES **Release of Information**

I hereby authorize release to Mariner Advanced Pharmacy Corp any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize Mariner Advanced Pharmacy Corp to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed.

YES **Assignment of Benefits**

I authorize direct payment of insurance benefits by my insurance company to Pharmacy In the event that my insurance carrier does not accept "assignment of benefits", I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Mariner Advanced Pharmacy Corp for payment of my bill.

YES **Financial Responsibility**

I understand that I am responsible to Mariner Advanced Pharmacy Corp for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay the rental and/or purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by Mariner Advanced Pharmacy Corp for invoiced charges.

Equipment Set-up and Instructions *(If Applicable)*

Please check the box next to each topic explained to you by a representative.

- ☐ Assemble and install equipment
- ☐ Perform safety and operation checks
- ☐ Environmental and safety checks
- ☐ Assess risk of patient harm resulting from falls
- ☐ Demonstrate equipment and give verbal instruction to patient and caregiver
- ☐ Instruct alternate caregiver if appropriate
- ☐ Review printed education material including printed safety precautions
- ☐ Physician's Rx for equipment use
- ☐ Customer's responsibility for routine maintenance, cleaning, infection control
- ☐ Mariner Advanced Pharmacy Corp address, phone, and business hours
- ☐ Delivery policy and follow-up policy
- ☐ Need to contact Mariner Advanced Pharmacy Corp if any change in patient status
- ☐ Procedure for non-operating equipment

I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND REFERENCED DOCUMENTS, INCLUDING THE HIPAA PRIVACY NOTICE AND MEDICARE SUPPLIER STANDARDS.

Client/ Caregiver Signature:_____ Relation to the Patient: _____ Date:_____	Delivery Staff:_____ _____ Remarks:_____ _____ _____

CLIENT MEDICATION PROFILE CHECKLIST

Please complete this form and return to pharmacy. A self-addressed, postage-paid envelope is included in this package for your convenience.

Client Name	Date of Birth
Allergies:	Ht:_____Wt:_____

Start Date	Medication	Dose	Route	Frequency	Stop Date
Please list all prescription medications including IV medications, solutions and flushes, oral prescription medications, Date over the counter medications, vitamins and home remedies. Update this form with all dose or medication changes.					
Signature:		Initials			

Prescription Delivery & Refill Enrollment Form

Patient Name: _____ Birth Date: _____ Phone#: _____

I understand that:

- Prescriptions will be delivered in a sealed, non-transparent.
- Same-day delivery is not available.
- Non-prescription items will not be delivered.
- Prior to prescription delivery, all co-payments and expenses **will be charged to the credit card on file**. No refunds will be given after receipt of medication(s).
- Special order items, transfers from other pharmacies, prescriptions ordered on Friday or a weekend, or prescriptions with no refills remaining may take additional time to be delivered.
- It is my duty to notify the Pharmacy by e-mailing info@marinerpharmacy.com as soon as possible of any changes including relocation of office/work area, home, and insurance information.
- I may revoke this authorization at any time by e-mailing info@marinerpharmacy.com.

Do you wish to consult with the "Pharmacist?"

- Your signature certifies you received a service or item dispensed on the date(s) listed below and that the information contain here on is correct or and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication and authorize release of all the information of prescription to which it correspond, to the plan administrator, the underwriter, the sponsor, the policyholder, the Workman's Compensation Commission (if applicable), and the employer. You hereby assign to this provider pharmacy and payment due pursuant to this transaction and authorize payment directly to this provider pharmacy.
  You agree to allow this pharmacy or its designee to mail to you prescription fill reminders and information about alternative and companion medications and products.. Pharmacy will comply with all applicable patient confidentiality laws.
  In addition, you understand that if payment for this service or item will be from Federal and State funds and that any false claims, statement or documents or concealment of material facts may be prosecuted under applicable Federal and State Laws. Furthermore, as required by State Laws you acknowledge receipt of an OFFER to COUNSEL and have accepted or refused counseling as indicated.
  WORKERS COMPENSATIVE ONLY: Your signature certifies that this medication is for the treatment of an on-the-job injury
  ALL OTHER THIRD PARTY PROGRAMS: Your signature certifies that this medication is not for treatment of an on-the-job injury

DELIVERY OR SHIPPING LOCATION:

□ Residence Address

_____
_____
_____

□ Other Designated Address-- [] *work* [] *Doctor Office* [] *Other*

_____
_____
_____

Please provide e-mail for notification of pending deliveries: E-mail: _____

Prescription charges will be billed to the patient's credit card on file.
I am willing to provide this information via phone or in person.

Package to be ship out with or without signature: (select & initial one below)

_____ *(Initial)* **SIGNATURE REQUIRED** *(adult signature required)*

_____ *(Initial)* **NO SIGNATURE REQUIRED** *(Releasing of signature means pharmacy will not be held liable for any loss or damaged package. All claims to be filed with third party shipper)*

DELIVERY/ SHIPPING AUTHORIZATION

I authorize Mariner Advanced Pharmacy to deliver/ship my prescriptions to the designated address as above.

Patient or Legal Guardian's Signature **Patient or Legal Guardian's Name** **Date**

REFILL ENROLLMENT

_____ *(Initial)* By checking this box, I choose to enroll one or more maintenance medications in the automatic refill program. Refills of my prescriptions may be requested for delivery or shipped via a third party shipper. I'm aware that I can cancel AUTO-REFILL program anytime by either call (650) 579-5678 or send email to info@marinerpharmacy.com

Check all that apply:

[ ] Auto-Refill & Ship

[ ] Auto-Refill and Call before ship or deliver

[ ] Auto-Refill and Call for pick up

Privacy Acknowledgement

Your signature acknowledges your receipt of our Notice of Privacy Practices (This notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get access to the information) and does not acknowledge your Agreement or any restriction you may request regarding your Protected Health Information.

Date_____

PATIENT DEMOGRAPHIC

Patient name_____ DOB _____

Adress_____City/State_____Zip_____

Email_____

Phone #1_____ Home/Cell/Work Phone #2_____ Home/Cell/Work

[ ] OK to leave voice message(s) [ ] OK to leave voice message(s)

Allergies(drug & reacion) _____

_____

Primary Doctor _____ Treatment Doctor _____

Rx INSURANCE INFO:

Rx Insurance Name_____ Rx Insurance ID_____

Rx Insurance Group_____ Rx Insurance BIN_____ Rx Insurance PCN_____

Rx Insurance Provider/Pharmacy Phone #_____ PRIMARY / SPOUSE / CHILD / OTHER

TRANSFER RX FROM YOUR CURENT PHARMACIES

BY INITIALING BELOW, YOU ARE AGREEING TO HAVE MARINER ADVANCED PHARMACY CORP. CONTACT YOUR CURRENT PHARMACY TO TRANSFER THE PRESCRIPTION(S)/MEDICATION(S) REQUESTED.

_____ INITIAL

Current Pharmacy_____

Address:_____

Rx # _____Medication_____ Prescribed by _____

Rx # _____Medication_____ Prescribed by _____

Rx # _____Medication_____ Prescribed by _____

Rx # _____Medication_____ Prescribed by _____

Rx # _____Medication_____ Prescribed by _____

MEDICATION(S)/VITAMIN(S) HISTORY:

List medication(s)/Vitamin(s) & reason of taking these medication(s) **[ ]** I'm currently not on any medication

#1 _____ For_____ Prescribed by _____

#2 _____ For_____ Prescribed by _____

#3 _____ For_____ Prescribed by _____

#4 _____ For_____ Prescribed by _____

#5 _____ For_____ Prescribed by _____