Saliba's
Extended Care Pharmacy
A Guardian Pharmacy®

To: Customers and their Family Members

Saliba's Extended Care Pharmacy is proud to have been chosen by the assisted living community where your loved one resides as their contracted pharmacy provider. This decision was based on several factors including:

1. Resident safety
2. Assurance that the facility will remain in compliance with State and Federal regulations
3. Consistency in systems and packaging
4. Convenience of residents and their families

Saliba's Extended Care Pharmacy is a locally owned Arizona company that has been serving the assisted living industry in Arizona for over 20 years. We specialize in providing services tailored to the needs of assisted living communities and their residents.

Our compliance assistive packaging makes it easier for caregivers and nurses to pass medications accurately and timely. By taking on much of the administrative responsibilities associated with obtaining and administering medications; we provide facility staff with more time to spend providing direct care to residents.

We also provide convenience and peace of mind for residents and their families. The services we provide allow you to rest assured that your medications will be there automatically without any effort on your part. Our Phoenix pharmacy is open 24 hours per day, 365 days per year and handles after-hours calls for the Tucson pharmacy. We interact directly with facility staff and prescribers to obtain prescription orders and we deliver all medications free of charge. All routine solid oral dosage forms (tablets and capsules) are provided automatically every 28 days. This obviates the need for residents or family members to go to the pharmacy to pick up medications several times per month.

All of this peace of mind comes at a price that is very comparable to the prices at retail community pharmacy chains. We accept almost all Medicare D, AHCCCS, and commercial insurance plans. Therefore co-pays should be the same at Saliba's Extended Care Pharmacy as they are at retail chains. With the exception of programs such as $4 generic programs; our non-insurance, cash prices are very competitive as well.

We appreciate the opportunity to serve your assisted living pharmacy needs. Please feel free to call us if you have any questions about our service, or billing.

Sincerely,

John Saliba, RPh
President

Phoenix Pharmacy: 925 E. Covey Lane, Phoenix, AZ 85024 ■ Phone: (623) 815-8965 ■ www.salibaspharmacy.com
Tucson Pharmacy: 10900 N. Stallard, Suite 120, Oro Valley, AZ 85737 ■ Phone: (520) 818-2883 ■ www.salibaspharmacytucson.com

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

As our customer, you are hereby provided this Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. We fulfill our obligation to protect and promote the rights of our patients, including the following:

RIGHTS: As the patient/caregiver, you have the right to:

- Be treated with dignity and respect
- Confidentiality of patient records and information pertaining to a patient's care
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care
- Be notified in advance of any change in your plan of care and treatment
- Be provided equipment and service in a timely manner
- Receive an itemized explanation of charges
- Be informed of company ownership
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property
- Be informed of potential reimbursement for services under Medicare, Medicaid or other 3rd party insurers based on the patient's condition and insurance eligibility
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third-party insurers. (to the best of our knowledge)
- Be notified within 30 working days of any changes in charges for which you may be liable
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed, if Saliba's Extended Care Pharmacy is unable to provide services then we will provide alternative resources
- Purchase inexpensive or routinely purchased durable medical equipment
- Expect that we will honor the manufacturer's warranty for equipment purchased from us
- Receive essential information in a language or method of communication that you can understand
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law

CLIENT RESPONSIBILITIES: As the patient/caregiver, you are RESPONSIBLE for:

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participation as in the plan of care/treatment.
- Notify the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses,
- hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

OUR RIGHTS: As your pharmacy of choice, we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our pharmacy to secure medication or durable medical equipment.
- To refuse services to anyone who enters our pharmacy and is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

INJURY PROTOCOL

In the event of an injury or death related to equipment failures provided by Saliba's Extended Care Pharmacy and its related entities would be reported to all authorities (state, local payer, accreditation provide as required). Saliba's Extended Care Pharmacy and its related entities reduces the risk through education and information provided to facilities, employees, and patients.

INFECTION CONTROL POLICY

Saliba's Extended Care Pharmacy and its related entities will maintain a plan of action regarding issues of infection and hazards by complying with CDC and OSHA standards, reviewing, updating, and reporting such concerns as they arise.

EMERGENCY PREPAREDNESS PLAN

Saliba's Extended Care Pharmacy and its related entities has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact Saliba's Extended Care and its related entities regarding any medications or supplies you may require when there is a threat of disaster or inclement weather so that you have enough medication or supplies to sustain you.

If a disaster occurs, follow instructions from the civil authorities in your area. Saliba's Extended Care Pharmacy and its related entities will utilize every resource available to continue to service you. However, there may be circumstances where Saliba's Extended Care Pharmacy and its related entities cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of your local rescue or medical facility. Saliba's Extended Care Pharmacy and its related entities will work closely with authorities to ensure your safety.

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Prior Authorizations and what they mean to Patients and Caregivers

What is a Prior Authorization?

A Prior Authorization is a utilization management process used by health insurances to establish that a specific case meets clinically driven, medically relevant criteria prior to the medication being approved.

When a medication that is not covered or requires prior authorization is submitted through an insurance plan, the claim will be rejected.

How is this process handled by the Pharmacy?

The care facility where the patient resides is notified via fax that the specific medication(s) require prior authorization. The medication rejection information is then cross-referenced by a Pharmacist. During this time period a Pharmacist will list any medications that are therapeutically equivalent. The Prior Authorization Team then runs test claims to ensure the alternative medications pay through the specific insurance plan. The medications that are verified as covered formulary alternatives are then sent to the Prescriber to decide if he or she would like to change the medication to the alternative. If there are no formulary alternatives the Prior Authorization documentation is started at the Pharmacy. The Prior Authorization Team will add all information that is available to the pharmacy and forward to the Prescriber for completion and submission to the insurance plan.

What does the Prescriber do?

The Prescriber will complete all related paperwork and provide a signature. This information must be submitted to the *insurance plan by the Provider or a Representative*.

A typical Prior Authorization takes at the least 72 hours for review. The Pharmacy will continue to follow up with the Prescriber during this time. If the medication is needed before it is approved, the option to pay cash may be available by contacting the Billing Team and verifying with the Prescriber. Once the medication is approved and the Pharmacy is notified, the medication is dispensed to the patient at their residing facility.

Please contact the Pharmacy Billing Department if we can provide any further clarity regarding Prior Authorizations or the process of determining medication coverage.

PAYMENT INFORMATION

Saliba's Extended Care Pharmacy offers three easy and convenient ways to pay your pharmacy bills.

ONLINE BILL PAY 💻

The online portal is flexible, easy to use, and available 24/7. Manage multiple users and accounts, monitor payment activity, view your statements and enroll in electronic statement delivery.

Create an account in our online payment portal to make a one-time payment or set up automatic recurring payments. Recurring payments take the hassle out of remembering to pay your bill by allowing you to choose the date that your monthly payment is processed. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express).

The link to the online portal for Saliba's Extended Care Pharmacy - Phoenix and Saliba's Extended Care Pharmacy - Tucson is https://guardian.account-access.net/cpo/com/etc/jcm/cpo/tmain. This can also be found on your monthly statements.

PAY BY PHONE ☎

Use our automated payment system to make a payment by phone using the access code and zip code listed on your statement. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express). Call 877-881-8583 for Saliba's Extended Care Pharmacy – Phoenix or 800-961-7165 for Saliba's Extended Care Pharmacy - Tucson. These numbers can also be found on each monthly statement.

PAY BY MAIL ✉

Mail in a check or money order payment directly to the address listed on your statement to make a payment. If paying by check or money order, please include your name or account number. If I send a non-sufficient funds check, I understand and agree that Saliba's Extended Care Pharmacy may charge a forty ($40) dollar service charge and give you an opportunity to rectify the payment by sending another check without a break in service.

Pharmacy addresses:

Phoenix:
Saliba's Extended Care Pharmacy
925 E Covey Lane
Phoenix, AZ 85024
(623) 815-8965

Tucson:
Saliba's Extended Care Pharmacy – Tucson
10900 N. Stallard Place, Suite 120
Oro Valley, AZ 85737
(520) 818-2883

If you have any questions regarding your bill or how to use one of these payment methods, please reach out to the Saliba's Extended Care Pharmacy billing team for assistance.

WHAT IS THE MEDICARE DONUT HOLE AND HOW DOES IT WORK?

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EXAMPLE MEDICARE DRUG PLAN FOR 2022

COVERAGE STATUS *You/Medicare*	**Your Actual Drug Cost**	**Your Out-of-Pocket Cost**
Deductible Period *You pay all/Medicare pays none*	$0-$480	$0-$480
Coinsurance/Copayment Period *You pay 25%/Medicare pays 75%*	$480-$4,430	$480-$1,467.50
Coverage Gap Period *You pay all/Medicare pays none*	$4,430-$10,012.50	$1,467.50-$7,050
Catastrophic Period *You pay 5%/Medicare pays 95%*	over $10,012.50	over $7,050

*The example above shows 2022 calendar year costs for covered drugs in a plan that meets Medicare's standards in 2022. Your costs may vary since each Medicare drug plan is structured differently. Plans may vary depending on deductible and copays.

YOUR YEARLY JOURNEY THROUGH THE DONUT HOLE

Deductible Period

You pay the first $480 of your actual drug cost before your Medicare coverage begins to pay.

Coinsurance/Copayment Period

You pay your coinsurance or copayment amount until the actual cost of your drugs reaches $4,430. *Note: This does not mean your out-of-pocket will be $4,430. The actual drug cost of $4,430 is based on your out-of-pocket plus what Medicare pays.*

Coverage Gap Period (Donut Hole)

You pay the cost of your drugs until your total out-of-pocket reaches $7,050. This includes amounts you paid earlier during your deductible and coinsurance/copayment period. Based on the example above, the most you would pay during the coverage gap period would be $5,583. In 2022, you will receive a 75% discount on covered brand drugs and 75% discount on generics during the coverage gap. Check with your plan to see if your drugs are eligible for the discount.

Catastrophic Coverage Period

You pay the reduced coinsurance or copayment amount set by your Medicare drug plan for the remainder of the year.

Note: People who have limited income and resources and qualify for full Extra Help or have additional coverage aren't affected by the gap in coverage. They would continue to pay the same copayment amount for each prescription they get.

CMS Publication No. 11213 Revised January 2022

BRIDGING THE COVERAGE GAP

Most Medicare drug plans (Part D) have a temporary limit on what they will cover for prescription drugs, or a "coverage gap." The good news is that all Medicare drug plans provide coverage if you have an unexpected illness or injury that results in extremely high drug costs. This is called "catastrophic" coverage. It assures that once you have paid $6,350 (in 2021) out-of-pocket for drug costs in a calendar year, almost all of your drug costs above that amount are covered. If your plan has a coverage gap during the time between a drug plan's standard level of coverage and the catastrophic coverage, you pay all of your drug costs. If you have limited income and resources, and qualify for full extra help, most of the information in this fact sheet **doesn't** apply to you. You will continue to pay the same copayment or coinsurance amount during a coverage gap if your plan has one. If your drug plan has a coverage gap, here are some ways you can avoid or delay entering the gap, and continue to save money on drug costs while in the gap:

•**Consider switching to generic, over-the-counter (OTC), or other lower-cost drugs.** Ask your doctor about generic, OTC, or less-expensive brand-name drugs that would work just as well as the ones you're taking now. Switching to lower-cost drugs may be enough to help you avoid the coverage gap and can save you hundreds or thousands of dollars a year. Cost savings information through the use of mail-order pharmacies, generic, or less-expensive brand-name drugs is also available by visiting the **Compare Medicare Prescription Drug Plans** section of www.medicare.gov.

•**Keep using your Medicare drug plan card**, even while in the coverage gap. Using your drug plan card ensures that you'll get the drug plan's discounted rates and that the money you spend counts toward your catastrophic coverage.

•**Explore National and Community-Based Charitable Programs** that might offer assistance (such as the National Patient Advocate Foundation or the National Organization for Rare Disorders). These organizations may have programs that can help with your drug costs. Comprehensive information on Federal, state, and private assistance programs in your area is available on the **Benefits Check Up** (www.benefitscheckup.org) website.

•**Look into Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs) that may be offered by the manufacturers of the drugs you take. Many of the major drug manufacturers are offering assistance programs for people enrolled in a Medicare drug plan. You can find out whether a Pharmaceutical Assistance Program is offered by the manufacturers of the drugs you take by visiting www.medicare.govand selecting "Lower Your Costs During the Coverage Gap."

•**Look at State Pharmaceutical Assistance Programs (SPAP)** for which you may qualify. There are 23 states and 1 territory offering some type of coverage to help people with Medicare with paying drug plan premiums and/or cost sharing. You can find out if your state has a State Pharmaceutical Assistance Program by visiting www.medicare.gov and selecting "Lower Your Costs During the Coverage Gap."

•**Apply for Extra Help**. If you have Medicare and have limited income and resources, you may qualify for extra help paying for your prescription drugs. Contact Social Security by visiting www.socialsecurity.gov or calling 1-800-772-1213. TTY users should call 1-800-325-0778.

NOTE: Not all types of coverage will count toward your out-of-pocket costs. Remember, after you have paid $6,350 (in 2021) out-of-pocket for drug costs in a calendar year, almost all of your drug costs above that amount are covered. If you want to switch to a plan that offers at least some type of coverage in the gap, you can do so between October 15th and December 7th each year. Your coverage will begin on January 1 of the following year.

For More Information All Medicare drug plans are different, so you should call your plan if you have questions about how the coverage gap will work for you. If you need help finding other resources, such as the ones described above, you can call your State Health Insurance Assistance Program (SHIP) for free personalized counseling to people with Medicare. To get their telephone number, visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites." You can also call 1-800-MEDICARE (1-800-633-4227).

CMS Publication No. 11213 Revised January 2022

Billing FAQs

1. **Why do you bill for a 28 day supply instead of a 30 or 90 day supply?**

   For the majority our assisted living homes we fill the patient's scheduled medications in what we call a cycle fill that is delivered every 28 days and medications that are taken as needed or that are in a non-pill form such as a cream or inhaler are dispensed as requested by the facility. For our skilled nursing facilities, we send medications in 7, 14 or 30 days supplies as requested by the facility. We do not dispense medications as a 90 day supply as we are not contracted with the insurances to do so. If you wish to receive a 90 day supply of medication, you will need to first make sure your facility allows medications to be brought in from an outside pharmacy and then contact your pharmacy provider to find out what options are available to you. If you do make the decision to use another pharmacy, please do not forget to let us know because otherwise we will continue to send medications and you will be responsible for paying for them.

2. **What is a cycle fill?**

   Cycle is only utilized at our assisted living homes. A cycle fill happens when we deliver all of the scheduled medications that are in a pill form for all of the patients at a facility on the same day. The cycle fill deliveries are made exactly every 28 days. We have made this arrangement with those facilities that utilize cycle fill to save them time and to ensure they are properly staffed on delivery days. This saves the facility and pharmacy time and money which keeps the cost of your services the lowest they can be.

3. **I already paid the facility, why am I now receiving a bill from Saliba's?**

   Unless a patient is staying at a skilled nursing facility under an authorized Medicare A stay, the patient or POA is responsible to pay for medications that were sent to the facility during their stay unless the facility has specifically instructed us to bill them for the patient's medications.

4. **Why was I billed for full cycle fills twice in the same month?**

   Cycle fill is billed every 28 days and since there are more than 28 days in each month, each year each home falls into a month where we bill at the very beginning and again 28 days later we bill again for the next cycle fill before the end for that month. For example, if we billed on January 1st we would need to bill again on January 28th for the next cycle fill. Because some months have more than 30 days, this would still happen if we sent all the medications every 30 days.

5. **Why did you send a partial quantity and then a fill full cycle fill?**

This happens anytime a new medication is added to the cycle fill between the homes regular cycle fill deliveries or when a patient starts on cycle fill between the homes regular cycle fill deliveries. For example, if it is 14 days until the homes regular scheduled cycle fill delivery we would fill for 14 days of that medication and then would deliver 28 day supply with the rest of their medications on the cycle fill delivery day. Medications are also put in as new on the cycle fill if the patient has left the facility and returned between the homes regular cycle fill deliveries like when a patient goes into the hospital. This is done because when a patient leaves a facility they are discharged from our system and then if they return we reenter them as a new patient. Due to the laws governing care facilities, many of them dispose of a patient's medications when they leave the facility so it is necessary for us to fill them again. We realize that the additional co-pays can be a financial burden and if this becomes the case please do not hesitate to contact our friendly billing staff to set up payment arrangements.

6. **Was my insurance billed?**

If we have your insurance on file we will make every attempt to submit our claims to them. The explanation of benefits that is provided by your insurance company should match the bills you receive from us but if they ever don't or you are unsure if we are using the correct insurance, please call our billing staff who will be happy to assist you.

7. **Isn't Medicare supposed to cover my medications?**

Medicare A and B cover hospital and doctor visits, skilled nursing stays, and durable medical equipment. Medicare D covers medications and is a separate benefit that you must sign up for in order to utilize.

8. **I thought I wasn't supposed to have co-pays since I'm on AHCCCS?**

Your co-pays are determined by the low income subsidy put in place for you in the Medicaid system. If you find yourself unable to pay the co-pays you are responsible for, you will need to contact your case manager to see if there is anything else they can do.

9. **What resources are available to help me pay for my medications?**

The Partnership for Prescription Assistance at 1-888-477-2669 or www.pparx.org can tell you which state, federal, and drug assistance programs are available to you. You can also try contacting Social Security at 1-800-772-1213 or www.ssa.gov to see if you qualify for "Extra Help"

10. **Can I make payments?**

Please call our billing team to discuss your specific situation.

11. <u>How do Medicare D plans work?</u>

When a patient has a Medicare D plan they may start the year paying a deductible. This is usually added to the cost of the patient's brand name medications. No Medicare drug plan may have a deductible more than $445. Some Medicare drug plans have no deductible.

Once the deductible is satisfied, patients pay their predetermined co-pays or coinsurance until they and their insurance combined have paid out $3820. Then the patient falls into the coverage gap or donut hole which means the patient is now responsible for 37% of the cost of their generic medications and no more than 25% of the cost of their brand name medications. This pricing continues until the patient has paid $5100.00 out of pocket for the year. Once the $5100.00 threshold is reached, the patient moves into the catastrophic coverage phase where there are small co-payments for all covered medications. The process starts anew on January 1st of the following year. Patients on AHCCCS and "extra help" generally do not have a coverage gap.

Medicare D plans will send the patient an Explanation of Benefits (EOB) which will explain these issues with details specific to their individual plans.

RESIDENT ENROLLMENT FORM

Saliba's Extended Care Pharmacy
A Guardian Pharmacy®

RESIDENT INFORMATION

RESIDENT NAME _____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# _____-_____-_____ DOB _____/_____/_____ □ MALE □ FEMALE

COMMUNITY NAME _____ APT # _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER _____

**A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE*

RESPONSIBLE PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____
[STREET] [CITY] [STATE] [ZIP CODE]

**MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS*

SECONDARY* _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

**SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT*

RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

TYPE OF CARD (circle): **VISA** **MASTERCARD** **AMERICAN EXPRESS** **DISCOVER**

NAME ON CARD: _____ **CARD NUMBER:** _____

BILLING ADDRESS: _____ **CITY, STATE, ZIP:** _____

SECURITY CODE: _____ **EXPIRATION DATE:** _____

*VISA/MC/DISCOVER: 3 digits on back of card
*AMEX: 4 digits on front of card

OR

ACCOUNT HOLDER NAME: _____

ACCOUNT ADDRESS: _____ **CITY, STATE, ZIP:** _____

BANK NAME: _____ **ROUTING #:** _____

CHECKING ACCOUNT #: _____

Please select an option below and sign.

☐ *I wish to pay automatically by credit card each month – please enroll me in auto-pay.*

☐ *I will mail in payment by check or call to pay by phone each month, promptly after receipt of Guardian's statement.*

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE _____

PHARMACY SERVICES AGREEMENT

Saliba's Extended Care Pharmacy
925 E Covey Lane • Phoenix, AZ 85024
(623) 815-8965 • (623) 815-1222

Saliba's Extended Care Pharmacy – Tucson
10900 N Stallard Place, Suite 120 • Oro Valley, AZ 85737
(520) 818-2883 • (520) 818-6546

This is an agreement for pharmacy services with Saliba's Extended Care Pharmacy and

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for Saliba's Extended Care Pharmacy's agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Saliba's Extended Care Pharmacy, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by Saliba's Extended Care Pharmacy. Saliba's Extended Care Pharmacy does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, Saliba's Extended Care Pharmacy may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize Saliba's Extended Care Pharmacy to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of Saliba's Extended Care Pharmacy supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by Saliba's Extended Care Pharmacy. If, for any reason, Saliba's Extended Care Pharmacy does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay Saliba's Extended Care Pharmacy directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account.
5. **PAYMENT OF BENEFITS.** I authorize Saliba's Extended Care Pharmacy to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to Saliba's Extended Care Pharmacy.
6. **ASSIGNMENT OF BENEFITS.** I authorize Saliba's Extended Care Pharmacy to request and collect on my behalf all public and private benefits due for the products and services supplied by Saliba's Extended Care Pharmacy. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Saliba's Extended Care Pharmacy.
7. **UNPAID INVOICES.** Saliba's Extended Care Pharmacy encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by Saliba's Extended Care Pharmacy related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Saliba's Extended Care Pharmacy reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to Saliba's Extended Care Pharmacy any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by Saliba's Extended Care Pharmacy. I also authorize all medical personnel to disclose information to Saliba's Extended Care Pharmacy relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to Saliba's Extended Care Pharmacy to use or disclose certain aspects of my health information to: the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

I have read and understand the above terms and conditions and agree to be bound by each of them:

Signature [Resident or Responsible Party]**:** _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of Saliba's Extended Care Pharmacy's privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that Saliba's Extended Care Pharmacy is committed to protecting my health information. I certify that I have read and understand this agreement:

_____**Resident or responsible Party Initial**

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of Saliba's Extended Care Pharmacy's Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

_____**Resident or responsible Party Initial**

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify that I have received a copy of Saliba's Extended Care Pharmacy's Injury, infection, and emergency preparedness protocol and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

_____**Resident or responsible Party Initial**

PAYMENT INFORMATION

I certify that I have received a copy of Saliba's Extended Care Pharmacy's payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

_____**Resident or responsible Party Initial**

I understand and have reviewed all of the above documents and agree to be bound as applicable.

Signature [Resident or Responsible Party]**:** _____ **Date:** _____

Saliba's Extended Care Pharmacy
A Guardian Pharmacy®

2022

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.

Guardian Pharmacy of Ari zona | Guardian Pharmacy of Tucson will ask you to sign an Acknowledgement that you have received this Notice of Privacy Practices {Notice). This Notice describes how Guardian Pharmacy of Ari zona may use and disclose your protected health information in accordance with the HIPM Privacy Ru le. It also describes your rights and Guardian Pharmacy of Ari zona' s duties with respect to protected health information about you.

Section A: Uses and Disclosures of Protected Health Information

1. Treatment, Payment and Health Care Operations
   a. We will use your health information to provide treatment. This may involve receiving or sharing information with other health care providers such as your physician. This information may be written, verbal, electronic or via facsimile. This will include receiving prescription orders so that we may dispense prescription medications. We may also share information with other health care providers who are treating you to coordinate the different things you need, such as medications, lab work or other appointments. We may also contact you to provide treatment -related services, such as refill reminders, treatment alternatives and other health related services that may be of benefit to you.
   b. We will use your health information to obtain payment. This will include sending claims for payment to your insurance or third-party payer. It may also include providing health h info rmation to the payer to resolve issues of claim coverage.
   c. We will use your health informat ion for our health care operations necessary to run the pharmacy. This may include monitoring the quality of care that our employees provide to you and for training purposes.
2. Permitted or Required Uses and Disclosures
   a. Our pharmacists, using t heir professional judgment may disclose your protected health information to a family member, other relative, close personal friend or other person you identify as being involved in your health care. This includes allowing such persons to pick up filled prescriptions, medical supplies or medical records on your behalf.
   b. We also have contracts with entities called Business Associates that perform some services for us that require access to your protected health information. Examples may include companies that route claims to your insurance company or that reconcile the payments we receive from your insurance. We require our Business Associates to safeguard any protected health information appropriately.
   c. Under certain circumstances Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson may be required to disclose health information as required or permitted by federal or state laws. These include, but are not limited to:
      i. To the Food and Drug Administration (FDA) relating to adverse events regarding drugs, foods, supplements and other health products or for post -marketing surveillance to enable product recalls, repairs or replacement.
      ii. To public health or legal authorities charged with preventing or controlling disease, injury or disability.
      iii. To law enforcement agencies as required by law or in response to a valid subpoena or other legal process.
      iv. To health oversight agencies (e.g., licensing boar ds) for activities authorized by law such as audit s, investigations and inspections necessary for Guardian Pharmacy of Arizona |

Guardian Pharmacy of Tucson's licensure and for monitoring of health care systems.

v. In response to a court order, administrative order, subpoena, discovery request or other lawful process by another person involved in a dispute involving a patient, but only if efforts have been made to tell the patient about the request or to obtain an order protecting the requested health information.
vi. As authorized by and as necessary to comply with laws relating to worker's compensation or similar programs established by the law.
vii. Whenever required to do so by law.
viii. To a Coroner or Medical Examiner when necessary. Examples include: identifying a deceased person or to determine a cause of death.
ix. To Funeral Directors to carry out their duties
x. To organ procurement organizations or other entities engaged in procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
xi. To notify or assist in notifying a family member, personal representative or another person responsible for the patient's care of the patient's location or general condition.
xii. To a correctional institution or its agents if a patient is or becomes an inmate of such an institution when necessary for the patient's health or the health and safety of others.
xiii. When necessary to prevent a serious threat to the patient's health and safety or the health and safety of the public or another person.
xiv. As required by military command authorities when the patient is a member of the armed forces and to appropriate military authority about foreign military personnel.
xv. To authorized officials for intelligence, counter intelligence and other national security activities authorized by law.
xvi. To authorized federal officials so they may provide protection to the president, other authorized persons or foreign heads of state or to conduct special investigations.
xvii. To a government authority, such as social service or protective services agency, if Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson reasonably believes the patient to be a victim of abuse, neglect or domestic violence but only to the extent required by law, if the patient agrees to the disclosure or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to the patient or to 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 the patient.

3. Authorized Use and Disclosure
   a. Use or disclosure other than those previously listed or as permitted or required by law, will not be made unless we obtain your written Authorization in advance. You may revoke any such Authorization in writing at any time. Upon receipt of a revocation, we will cease using or disclosing protected health information about you unless we have already taken action based on your Authorization.
4. More Stringent Laws
   a. Some states may have laws that are more stringent than HIPAA. Please refer to the end of the Notice for the laws that may apply.

Section B: Patient's Rights

5. Restriction Requests
   a. You have a right to request a restriction be placed on the use and disclosure of your protected health information for purposes of carrying out treatment, payment or health care operations. Restrictions may include requests for not submitting claims to your insurance or third -party payer or limitations on which persons may be considered personal representatives.

a. Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson is not required to accept restrictions other than payment related uses not required by law that have been paid in full by the individual or representative other than a health plan.
b. If we do agree to requested restrictions, they shall be binding until you request that they be terminated.
c. Requests for restrictions or termination of restrictions must be submitted in writing to the Privacy Officer listed in Section D of this Notice.

2. Alternative Means of Communication
   a. You have a right to receive confidential communications of protected health information by alternate methods or at alternate locations upon reasonable request. Examples of alternatives may be sending information to a phone or mailing address other than your home.
   b. Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson shall make reasonable accommodation to honor requests.
   c. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
3. Access to Health Information
   a. You have a right to inspect and copy your protected health information. The designated record set will usually include prescription and billing records. You have the right to request the protected health information in the designated record set for as long as we maintain your records.
   b. You have the right to request that your protected health h information be provided to you in an electronic format if available.
   c. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
   d. Any costs or fees associated with copying, mailing or preparing the requested records will be charged prior to granting your request.
   e. Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson may deny your request for records in limited circumstances. In case of denial, you may request a review of the denial for most reasons. Requests for review of a denial must also be submitted to the Privacy Officer listed in Section D of this Notice.
4. Amendment s t o Health Information
   a. If you believe that your protected health information is incomplete or incorrect, you may request an amendment to your records. You may request amendment to any records for as long as we maintain your records.
   b. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
   c. Requests must include a reason that supports the amendment to your health information.
   d. Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson may deny amendment requests in certain cases. In case of denial, you have the right to submit a Statement of Disagreement. We have the right to provide a rebuttal to your statement.
5. Accounting of Uses and Disclosures
   a. You have the right to request an accounting of uses and disclosures that are not for treatment, payment or health care operations. This accounting may include up to the six years prior to the date of request and will not include an accounting of disclosures to yourself, your personal representatives or anything authorized by you in writing. Other restrictions may apply as required in the Privacy Ru le.
   b. Requests must be submitted in writing to the Privacy Officer listed in Section D of this Notice.
   c. The first accounting in any 12-month period will be provided to you at no cost. Any additional requests within the same 12-month period will be charged a fee to cover the cost of providing the accounting. This fee amount will be provided to you prior to completing the request. You may choose to withdraw your request to avoid paying this fee.
6. Notice of Privacy Practices

a. You have a right to receive a paper copy of this Notice even if you previously agreed to receive a copy electronically.
b. Please submit a request to the Privacy Officer listed in Section D of this Notice.

Section C: Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson's Duties

Guardian Pharma cy of Arizona is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.
Guardian Pharma cy of Arizona is required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make the new notice provisions effective for all protected health h information that we maintain. Any such revised Notice will be made available upon request.

Section D: Contacting Us

1. Additional Questions, Submitting Requests or Complaints
    a. If you have questions about this Notice or how Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson uses and discloses your protected health information please contact our Privacy Officer below.
    b. You may obtain forms needed for request submission from our pharmacy or from our Privacy Officer.
    c. If you believe your privacy rights have been violated you may file a complaint with our Privacy Officer or with the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.
2. Privacy Officers

Debbie Harris
Guardian Pharmacy of Arizona
925 E Covey Lane
Phoenix, AZ 85024
(623) 742-2453

Felicia Campbell
Guardian Pharmacy of Tucson
10900 N Stallard Place, Suite 120
Oro Valley, AZ 85737
(520) 818-2883

3. Secretary of Health and Human Services, Office for Civil Right s
    a. For online complaint forms and contact information for the Regional OCR off ices: http:// www.hhs.gov/ocr/ privacy/ index.htm l
    b. Email: OCRComplaint@hhs.gov for assistance or questions about complaint forms

Section E: State Specific Requirements

None
Version# 0323787-PMS-2013-2.0
Effective Date
This Notice of Privacy Practices is effective as of 01-01 -2019

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2022

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson' s Notice of Privacy Practices.

_____ ___/___/____

Name of Patient (Please Print) Date of Birth

_____ ___/___/____

Signature of Patient or Persona l Representative Date

_____ _____

Name of Personal Representative (Please Print) Relationship to Patient

Documentation of Good Faith Effort to obtain acknowledgment of receipt of Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

I certify that on ___/__/____ mm/dd/yyyy), made a good faith effort to obtain the above patient's written acknowledgement of his/her receipt of Guardian Pharmacy of Arizona | Guardian Pharmacy of Tucson Notice of Privacy Practices. However, such acknowledgment was not obtained because:

☐ Patient refused to sign

☐ Patient was unable to sign or initial because:

_____

☐ The Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ A copy of the Notice was **MAILED/ E-MAILED** (circle one) to most recent address on file.

☐ Other Reason: _____

_____

Printed name of employee completing form

_____ ____/__/_____

Signature of employee completing form Date

**Per HIPAA documentation requirements, pharmacy must keep the patient's signature acknowledging receipt of Notice of Privacy Practices for a minimum of six years.*