Gulfcoast Pharmaceutical Specialty, LLC
1039 E. Highway 30
Gonzales, LA 70737
(800) 498-5220 main
(844) 337-6197 fax

Pharmacy Consent Form

Resident Name: _____
First Middle Init. Last

Facility Name: _____

Facility Address: _____

Resident Room/Suite/Apt#: _____ D.O.B. _____ Gender: M or F

Social Security #:_____ Medicare#:_____

Medicaid#:_____ Insurance:_____

Pharmacy where meds last filled & phone#:_____

How would you like your meds packaged: Bottle (Easy off cap), Blister card or Multidose Pouch

Primary Doctor:_____

Allergies:_____ Automatic Fill: YES NO

Do you use a Med Pass service? YES NO MedPass Company Name_____

Name of Responsible Party:_____

Relationship to Resident:_____

Billing address:_____
Suite/Apt/Rm

City/State/Zip:_____

Phone: _____ _____
(home) (cell)

Would you like to have your bill emailed? (circle one) YES NO

Email: _____

****Please provide a front and back copy of any insurance cards for the above resident so we may bill insurance.****

I authorize the facility to order medications for the above named resident from **Gulfcoast Pharmaceutical Specialty**. I understand that the undersigned will be responsible for all charges not covered by Medicaid, Medicare, or Private Insurance.

_____

Signature of Responsible Party *Date*

NOTICE OF PRIVACY PRACTICES

September 22, 2013

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.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Facility has created this Notice of Privacy Practices (Notice). This Notice describes the Facility's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Facility protect the privacy of your PHI that the Facility has received or created.

This Facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Facility reserves the right to change the Facility's privacy practices and this Notice.**

HOW THE FACILITY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Facility is permitted, by law, to use and disclose your PHI.

Uses and disclosures of PHI for Treatment: We will use the PHI that we receive from you to fill your prescription and coordinate or manage your health care.

Uses and disclosures of PHI for Payment: The Facility will disclose your PHI to obtain payment or reimbursement from insurers for your health care services.

Uses and disclosures of PHI for Health Care Operations: The Facility may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Facility workforce.

The following is an accounting of additional ways in which the Facility is permitted or required to use or disclose PHI about you without your written authorization.

Uses and disclosures as required by law: The Facility is required to use or disclose PHI about you as required and as limited by law.

Uses and disclosure for Public Health Activities: The Facility may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.

Uses and disclosure about victims of abuse, neglect or domestic violence: The Facility may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.

Uses and disclosures for health oversight activities: The Facility may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.

Disclosures to Individuals Involved in your Care: The Facility may disclose PHI about you to individuals involved in your care.

Disclosures for judicial and administrative proceedings: The Facility may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Facility.

Disclosures for law enforcement purposes: The Facility may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.

Uses and disclosures about the deceased: The Facility may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes: The Facility may use and disclose PHI for the purpose of procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.

Uses and disclosures for research purposes: The Facility may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Facility will request a signed authorization by the individual for all other research purposes.

Uses and disclosures to avert a serious threat to health or safety: The Facility may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

Uses and disclosures for specialized government functions: The Facility may use or disclose PHI about you for specialized government functions including; military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

Disclosure for workers' compensation: The Facility may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

Disclosures for disaster relief purposes: The Facility may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

Disclosures to business associates: The Facility may disclose PHI about you to the Facility's business associates for services that they may provide to or for the Facility to assist the Facility to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

OTHER USES AND DISCLOSURES

The Facility may contact you for the following purposes:

Information about treatment alternatives: The Facility may contact you to notify you of alternative treatments and/or products.
Health related benefits or services: The Facility may use your PHI to notify you of benefits and services the Facility provides.
Fundraising: If the Facility participates in a fundraising activity, the Facility may use demographic PHI to send you a fundraising packet, or the Facility may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt-out of all future fundraising activities.

FOR ALL OTHER USES AND DISCLOSURES

The Facility will obtain a written authorization from you for all other uses and disclosures of PHI, and the Facility will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact Scott Black to obtain a *Request for Restriction of Uses and Disclosures*.

YOUR HEALTH INFORMATION RIGHTS

The following are a list of your rights in respect to your PHI. Please contact the Scott Black for more information about the below.

Request restrictions on certain uses and disclosures of your PHI: You have the right to request additional restrictions of the Facility's uses and disclosures of your PHI; however, the Facility is not required to accommodate a request. This includes the right to restrict disclosures to Insurances for those products and services you pay out-of-pocket for.

The right to have your PHI communicated to you by alternate means or locations: You have the right to request that the Facility communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Facility to have an accurate address and home phone number in case of emergencies. The Facility will consider all reasonable requests.

The right to inspect and/or obtain a copy your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Facility for the duration the Facility maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges, if any.

The right to amend your PHI: You have the right to request an amendment of the PHI the Facility maintains about you, if you feel that the PHI the Facility has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.

The right to receive an accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the Facility.

The right to receive additional copies of the Facility's Notice of Privacy Practices: You have the right to receive additional paper copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically

Notification of Breaches: You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact Scott Black if you wish to file a complaint with the Secretary, please write to:

http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

The Facility will not take any adverse action against you as a result of your filing of a complaint.

CONTACT INFORMATION

If you have any questions on the Facility's privacy practices or for clarification on anything contained within the Notice, please contact:

Gulfcoast Pharmaceutical Specialty, Llc
Scott Black
1039 East Highway 30
Gonzales, LA 70737
(225) 647-4182

Acknowledgement Of Receipt Of The Notice Of Privacy Practices

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices:

_____
Individual's Signature

_____
Individual's Printed Name

_____
Date

Documentation of Good Faith Effort

The Facility made a good faith effort to obtain a written acknowledgment of the individual's receipt of the Notice but a written acknowledgment was not received for the following reason:

☐ Individual refused to sign.

☐ Individual was not able to sign. (*Please specify below)*:

_____

_____

☐ Emergency

☐ Other (*please specify below)*:

_____
Employee's Signature

_____
Date

☐ New Enrollment ☐ Change in Banking Information

GPS Pharmacy - Direct Debit Authorization Form Questions? Call 225-647-4182

GPS Account #_____

Credit / Debit Card (Select One) ☐ Mastercard ☐ Visa ☐ Discover Card ☐ American Express

Name on Card: _____

Card Number: _____ Exp Date: _____ CSC# _____
(3 digit code on back of card)

Cardholder Signature: _____

Billing Address (for Card): _____
Street/ City/State/ Zip

ACH Debits

Gulfcoast Pharmaceutical Specialty (GPS) is hereby authorized to Instruct JPMorgan Chase Bank to present automated clearing house (ACH) debits on my account indicated below and the depository named below for payment of settlements due by the client of GPS.

Account Name: _____

Bank Name: _____

Bank Address: _____

City _____

State: _____ Zip: _____

Account Number: _____

Routing Number: _____

Phone Number: _____

**** To complete ACH Enrollment a Voided check MUST be attached.**

☐ **Check box if you would like to set up automatic monthly charges using this card/account.**

☐ **Check box if you would like make a one time payment using this card/account. Payment Amount: $_____**

Authorized Name: _____

Authorized Signature: _____ Date: _____

This arrangement does not affect our primary obligation for payment. This authorization is to remain in effect until you are notified in writing or we receive written notification from you.

If you prefer to pay by check, Please mail checks to:
GPS Pharmacy
P.O. Box 489
Gonzales, LA 70737

PAY YOUR BILL ONLINE AT
WWW.GPSPHARMACY.NET

Scan to make online payment

Payment link is on the bottom of the Contact Us page
Or Visit
HTTPS://GPSSPECIALTY.MYPAYSIMPLE.COM/S/PAYMENT-FORM