



Frequently Asked Questions

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## Frequently Asked Questions

**Question: How is Albright Pharmacy Services different from a retail chain like CVS?**

**Answer:** Albright Pharmacy Services is designed specifically to meet your needs as a continuing care retirement community resident. While we primarily serve residents of skilled nursing and assisted living, we serve many residents living independently, too.

When you are a customer with Albright Pharmacy Services, your prescriptions seamlessly follow you to skilled nursing/rehabilitative services or assisted living.

We will happily work with you and your physician to fill your prescriptions. We are happy to speak with residents about other non-prescription health and wellness products that may make sense for us to add to our selection.

**Question: Will Albright Pharmacy Services meet my needs as the current pharmacy does?**

**Answer:** Yes! We hire compassionate and dedicated staff who understand what you are being prescribed and provide free consultation on interactions and new medications.

- We offer a range of customized packaging that supports medication regimen adherence.
- Free on-campus delivery services will be provided.
- Walk-in customers are welcome, and we provide free consultation.
- We seek to be as cost-effective as possible and completely customer-centric.

**Question: Will Albright Pharmacy Services work with my insurance company?**

**Answer:** Our goal is to be as comprehensive as possible in working with all major health plans and insurance networks. Closed door Pharmacies (like Albright Pharmacy Services) contract with PBM's (Pharmacy Benefit Managers), who process prescription claims on behalf of individual health plans/insurance networks. Since Pharmacy Benefit Managers do not typically publish their customer lists (the insurance companies they represent), the local dispensing pharmacy generally will not know which individual health plans fall within those covered networks. To confirm prescription coverage with any pharmacy, the beneficiary should contact their insurance provider directly for guidance on the matter. The dispensing pharmacy is able to confirm active coverage upon submission of a claim, at a point of sale.

**Question: What if I'm prescribed a *specialty medication* not available at most retail chains?**

**Answer:** If you are currently (or in the future) prescribed a "specialty medication" (one in which the pharmacy would need a special purchasing contract to procure, based on significant clinical monitoring and advanced practices in dispensing), our dedicated staff would be happy to help liaise these needs to a providing pharmacy, unburdening you from having to source the medication yourself.

# 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.**

As part of the Federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Pharmacy has created this Notice of Privacy Practices (Notice). This Notice describes the Pharmacy'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 Pharmacy protect the privacy of your PHI that the Pharmacy has received or created.

This Pharmacy 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 Pharmacy 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 Pharmacy reserves the right to change the Pharmacy's privacy practices and this Notice.**

## **HOW THE PHARMACY MAY USE AND DISCLOSE YOUR PHI**

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

**Uses and disclosures of PHI for Treatment:** The Pharmacy will use the PHI that it receives from you to fill your prescription and coordinate or manage your healthcare.

**Uses and disclosures of PHI for Payment:** The Pharmacy will disclose your PHI to obtain payment or reimbursement from insurers for your healthcare services.

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

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

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

**Uses and disclosure for Public Health Activities:** The Pharmacy may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purposes 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 Pharmacy 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.

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**Uses and disclosures for health oversight activities:** The Pharmacy 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 Pharmacy may disclose PHI about you to individuals involved in your care. Disclosures for judicial and administrative proceedings: The Pharmacy may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Pharmacy.

**Disclosures for law enforcement purposes:** The Pharmacy 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 for cadaveric organ, eye, or tissue donation purposes:** The Pharmacy 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 Pharmacy 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 Pharmacy 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 Pharmacy 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 Pharmacy may use or disclose PHI about you for specialized government functions including military and veterans' activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

**Disclosure for workers' compensation:** The Pharmacy 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 Pharmacy 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 Pharmacy may disclose PHI about you to the Pharmacy's business associates for services that they may provide to or for the Pharmacy to assist the Pharmacy to provide quality healthcare. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

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## OTHER USES AND DISCLOSURES

The Pharmacy may contact you for the following purposes:

**Information about treatment alternatives:** The Pharmacy may contact you to notify you of alternative treatments and/or products.

**Health-related benefits or services:** The Pharmacy may use your PHI to notify you of benefits and services the Pharmacy provides.

**Fundraising:** If the Pharmacy participates in a fundraising activity, the Pharmacy may use demographic PHI to send you a fundraising packet, or the Pharmacy 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 Pharmacy will obtain a written authorization from you for all other uses and disclosures of PHI, and the Pharmacy 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 the Pharmacy 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 Pharmacy 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 Pharmacy's uses and disclosures of your PHI; however, the Pharmacy is not required to accommodate a request. This includes the right to restrict disclosures to insurances for those products and services you pay for out-of-pocket.

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

**The right to inspect and/or obtain a copy of your PHI:** You have the right to request access and/or obtain a copy of your PHI that is contained in the Pharmacy for the duration the Pharmacy maintains your PHI. 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 Pharmacy maintains about you, if you feel that the PHI the Pharmacy has maintained about you

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is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If the Pharmacy does 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 Pharmacy.

**The right to receive additional copies of the Pharmacy'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 Pharmacy 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 Pharmacy will also post the revised version of the Notice in the Pharmacy.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Pharmacy and/or to the Secretary of HHS, or its designee. If you wish to file a complaint with the Pharmacy, please contact Albright Pharmacy Services. If you wish to file a complaint with the Secretary of HHS, please write to:

<http://www.hhs.gov/ocr/office/aboput/rgn-hqaddresses.html>

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

## **CONTACT INFORMATION**

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

**Albright Pharmacy Services**  
**333 Russell Avenue, Suite 100**  
**Gaithersburg, MD 20877**

**Phone (301) 216-5216**  
**Fax (301) 216-5221**

**Asbury.org/pharmacy**

# Permission for Release of Information



Patient Name	Date of Birth
Address	Telephone #

## Please mark the records you are allowing access to:

- ☐ Patient File (demographic info)      ☐ Payment information  
☐ Insurance Data      ☐ Medical Expense Summary  
☐ Prescription Profile      ☐ Other: \_\_\_\_\_

**I am requesting that the following individuals have access to my Protected Health Information (PHI) and medical records:**

### Primary (Power of Attorney):

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Receive monthly pharmacy statements?: ☐ Yes ☐ No

### Secondary:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Receive monthly pharmacy statements?: ☐ Yes ☐ No

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Representative's relationship to Patient: \_\_\_\_\_

**Completed forms can be faxed to (301) 216-5221**

**or mailed to:**

**Albright Pharmacy Services**

**333 Russell Avenue, Suite 100**

**Gaithersburg, MD 20877**

# Pharmacy Services Record and Agreement



\_\_\_\_\_  
Community/Location Name

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: ☐ M ☐ F

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Resident is solely responsible for the legal and financial authorizations: ☐ Yes ☐ No

If NO, please list the legal representative below:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Legal Representative Address: \_\_\_\_\_

LR's City: \_\_\_\_\_ LR's State: \_\_\_\_\_ LR's Zip: \_\_\_\_\_

LR's Phone: \_\_\_\_\_ LR's Email: \_\_\_\_\_

## PRIMARY CONTACT & FINANCIAL RESPONSIBLE PARTY INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Responsible Party Address: \_\_\_\_\_

RP's City: \_\_\_\_\_ RP's State: \_\_\_\_\_ RP's Zip: \_\_\_\_\_

RP's Phone: \_\_\_\_\_ RP's Email: \_\_\_\_\_

Primary contact is also Financially Responsible Party: ☐ Yes ☐ No

If NO, please list the Financially Responsible Party below:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Responsible Party's Address: \_\_\_\_\_

RP's City: \_\_\_\_\_ RP's State: \_\_\_\_\_ RP's Zip: \_\_\_\_\_

RP's Phone: \_\_\_\_\_ RP's Email: \_\_\_\_\_

\*A Responsible Party is a person, other than the Patient, who agrees to be responsible for payment of all amounts owed by the Patient for products and services provided to the Patient.



## Pharmacy Services Record and Agreement



### PHYSICIAN INFORMATION

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Physician's City: \_\_\_\_\_

Physician's State: \_\_\_\_\_ Physician's Zip: \_\_\_\_\_

### NON-COVERED MEDICATION INSTRUCTIONS

Please indicate the preferred method for handling medications not covered by insurance.

- ☐ Dispense all medications (prescription and over-the-counter, whether covered by insurance or not)
- ☐ Dispense all covered medications and send a seven-day supply or smallest package size available
- ☐ Only dispense medications covered by insurance (items not covered, will not be dispensed)

### PAYMENT SOURCES FOR PHARMACY PRODUCTS AND SERVICES

To assist in billing for products and services provided to the patient, check all pay sources that apply:

☐ Medicare (Medicare effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_)

☐ No Prescription Insurance (CASH)

☐ Third Party Insurance (including Medicare Part D):

Plan Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ BIN/PNC #: \_\_\_\_\_

☐ Medicaid #: \_\_\_\_\_ State: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Hospice: \_\_\_\_\_ Hospice Phone: \_\_\_\_\_

**\*Please provide pharmacy with copies (front and back) of ALL Drug Coverage Cards**

## Pharmacy Services Record and Agreement



### AUTHORIZATION FOR PAYMENTS

☐ Credit Card      ☐ I authorize automatic and continuous billing, on a Monthly basis

☐ Visa      ☐ Mastercard      ☐ American Express      ☐ Discover

Credit Card number: \_\_\_\_\_ Exp: \_\_\_\_/\_\_\_\_ Security Code: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

☐ Bank Account Withdrawal      Bank Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Account number: \_\_\_\_\_ Routing number: \_\_\_\_\_

**Assignment of Benefits:** I assign the right and responsibility to Albright Pharmacy Services, to bill on my behalf and accept payment for Medicare/Medicaid services provided to me, the Beneficiary. I understand that I am responsible to pay any deductible applied to the claims and the copayment amounts, or approved charge for a product or service. I permit Albright Pharmacy Services to release and collect my health information and other information, as required (and as permitted by HIPAA regulations) from my health care providers and insurance provider to receive payment from my insurance coverage. I understand that this form will be maintained and made available to my insurance provider or its representatives.

**Privacy Acknowledgement:** I acknowledge that I have received a copy of the facility's 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.

**By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the terms described within this document.**

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*Patient/Patient's Representative Name (Please Print)*

*Signature*

*Date*

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*Financial Responsible Party Name (Please Print)*

*Signature*

*Date*



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PHARMACY  
SERVICES



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