Patient Information

Last Name	First Name	Middle Initial	Gender: □ M □ F

Date of Birth	Social Security #	Phone Number	Requested Start Date

Physical Address	Mailing Address (if different)

Power of Attorney: □ Yes □ No If yes, Name of POA: _____ (Supporting documentation must be provided)	Caregiver Name & Phone	Emergency Contact Name & Phone

Medical Information

Allergies	Other services I'm interested in: □ Medical Equip & Services □ Breast Pumps □ Incontinence Supplies □ Home Infusion

Previous Pharmacy & Phone	Doctor & Phone

Filling Frequency: □ 30 days □ 28 days □ 14 days	Requested Packaging: □ Bottles □ Dispill Packaging (Multi-Med)	____ Initial to authorize cycle fill & automatic prescription refills

How would you like to receive your prescriptions? □ Delivery □ Pick-up □ Mail

If mail or delivery, please indicate address & any special instructions:

Authorized Individuals

The following individuals are authorized to reorder, pickup and receive medications for me. Please be aware Big Sky Managed Care (the "Pharmacy") will require ID to ensure medications are given to the appropriate person. I will notify the Pharmacy if/when this information needs to be updated.

Authorized Individuals_____

Please indicate delivery address, if different than patient's: _____

Patient Responsibility

Medication profiles are accurately maintained to the best of our capabilities; however, we cannot reasonably accommodate changes that are not communicated to us. Upon receiving medications, it is the patient/caregiver's responsibility to review the supplied materials for discrepancies such as discontinued meds, dose changes and missing medications. Any and all inconsistencies must be reported to the pharmacy in a timely fashion and we will do our part to ensure that orders are clarified and medication profiles are updated.

Initial

Privacy Notice

I certify that I have received a copy of the privacy notice (HIPPA) and have reviewed the document. I acknowledge the Pharmacy is committed to protecting my health information.

Initial

BIG SKY MANAGED CARE Rx

Montana Owned and Operated.

900 13th Ave S.
Great Falls, MT 59405

P: (406) 315-1989 F: (406) 315-1988
bigskymanagedcare.com

Patient Insurance Information

Group: _____

Policy/ID #: _____

BIN #: _____

PCN/Processor #: _____

Insurance Name: _____

Insurance Phone #: _____

□ Please indicate here if more than one insurance plan is to be used – attach copies

Medicaid Card #

Medicare Part B #

Responsible Party / Payee Information

*** CREDIT CARD AUTHORIZATION FORM ***

I understand the Pharmacy can provide for regular automatic payments from an established credit card. I authorize the Pharmacy to charge automatically to my credit card monthly payments owed on the monthly statement for the above client. I understand I will continue to receive a monthly statement for my information and review. I acknowledge the Pharmacy will be storing my credit card information on a secure server for billing purposes only. I understand upon receiving notification of the client above leaving the facility above, the Pharmacy will charge any remaining balance on the client's file to close out the account. Any medications not picked up after 7 days will be mailed to the address on file and charges will be debited from card. I understand I am required to pay all my co-pays at the time of service as required by my insurance company.

Card Type □ Visa □ MasterCard □ AMEX □ Discover

Name of cardholder: _____ Card Number: _____

Card Exp: _____ Security Code (cvv): _____ Billing Zip Code: _____

Child Safety Waiver

I request all medications, now and in the future, be dispensed in a non-child resistant container. I agree to waive the child-resistant safety cap requirement for all new prescriptions and refills. Big Sky Managed Care packs are not child safe and should be kept out of the reach of children at all times.

Initial ⇨

Repackaging Waiver

Repackaging Waiver of Liability: I understand I am requesting Big Sky Managed care to repackage my medications from their original containers into a multi-dose packaging system. The Pharmacy reserves the right to repack medications even when the manufacturer's guidelines recommend otherwise.

*Packaged meds cannot be returned for credit, due to hygienic and allergy issues.

I understand it is my responsibility to notify the Pharmacy of any issues with delivered and prepackaged meds in a timely manner.

Initial ⇨

Patient or Legal Representative's Signature

By signing below, I acknowledge I have read and understand all of the above initialed statements.

Sign ⇨ _____

Signature **Today's Date**

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FINANCIAL POLICY

We have eliminated costly bookkeeping and billing fees by requiring payment at time of service for patients not residing in a long-term care facility. We accept cash, check and all major credit cards and most Health Savings cards. We will make every reasonable effort to avoid a misunderstanding, to rectify a mistake in billing, or to preserve a friendship we have worked for.

INSURANCE POLICY

We accept assignment on Medicare, Medicaid, and most commercial insurance plans that have pharmacy benefits associated with them. You are responsible for any deductibles, co-pays or non-covered services provided. It is important that you know insurances may not cover at 100% on your claims. We encourage you to contact your insurance company with specific questions on what is and is not covered by your plan.

Further, patients must realize that professional services are rendered to a person, not to an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. We cannot render services on the assumption that the charges will be paid in full or in part by the insurance company.

COMMONLY ASKED QUESTIONS ON SERVICE

-Do I have to pay my co-pay at the time of service? Yes, you are expected to pay co-pays at time of service. We accept cash, check, and credit card.

-Do I need to let you know if my insurance changes? Yes, and claims that will need to be run through your insurance if it becomes invalid will default to patient responsibility.

Your Information. Your Rights. Our Responsibilities.

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**.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- Treat you - We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- Bill for your services- We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective August 17, 2022

Privacy Office:

Big Sky Managed Care
900 13th Ave S
Great Falls MT 59405
406-315-1989