AristaCare

Patient Information Handbook

Important Message

It is very important for you to read through this handbook.

It is important that as soon as you receive your first delivery, to read, sign and return the forms included in the back of this book.

Please make sure to include the signed Customer Agreement, Informed Consent and delivery ticket in the enclosed stamped envelope.

Please call us if you have any questions.

Thank you.

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Dear Valued Patient,

WELCOME TO ARISTACARE.

Thank you for choosing our pharmacy to fulfill your medication needs. Your care is very important to us. We have developed this patient admission booklet to introduce you to our services.

OUR MISSION

Our mission at AristaCare is to help achieve the best possible outcomes for all patients through optimal pharmaceutical care, collaboration with other healthcare professionals, and educational initiatives to advance pharmaceutical knowledge.

OUR VISION

Our vision is to be recognized for the quality and diversity of our services, professional leadership, educational excellence, and for advancing the accessibility of pharmacy services through the innovative use of human and technology resources.

How to Contact Us

Our toll-free phone number is: **844.376.2784**. We are available to assist you 24 hours/day. Please call us with any infusion questions you may have. Please be assured your call will be answered by a member of our care team. If you are in need of assistance after hours, one of our clinicians is always on call to assist you, just call our toll free number.

Your prescriber may send prescriptions to us via fax at **847.306.3597**, or call us at: **844.376.2784**.

Please visit our website: **aristacarehealth.com**

We are pleased that you have entrusted your pharmaceutical care to us.
We will do our very best to support you through your therapy.
Feel free to call us any time you need us — We are here to help!

Sincerely,
The AristaCare Team

General Information

SERVICES: AristaCare provides comprehensive infusion services including nursing, and medical supplies within our service area. We provide these services to our customers with quality care in a timely manner. Services appropriate to your needs will be coordinated and under the direction of your physician and our highly experienced and trained staff.

OFFICE HOURS: Our Office hours are Monday through Friday from 8:00 AM to 5:00 PM. We are available 24 hours/day to service your needs.

AFTER HOURS COVERAGE: AristaCare has clinicians on call 24 hours a day, 7 days a week. You can reach us by calling **844.376.2784** and then follow the prompts. Qualified personnel are on-call after hours to respond to your needs and for any referrals for services.

MEDICAL EMERGENCIES: In case of a medical emergency, go to your nearest hospital emergency room or call Emergency Medical Services (911).

Note: Please notify our office in the event that you are admitted to the hospital or taken to the emergency room.

MEDICAL and PHARMACY CLAIMS: AristaCare accepts payment from government agencies as well as private insurance and self-pay. Some insurers limit the type and quantity of supplies, equipment and visits they will cover and require prior approval and/or copayments. All coverage requirements from the insurance company must be met or payment becomes a customer responsibility.

CUSTOMER SATISFACTION: Our customers are very important to us. Please ask questions if something is unclear regarding our services or the care you receive or fail to receive. Our company sends out a satisfaction survey. Your answers help us to improve our services and ensure that we meet your needs and expectations. When you receive one, please complete the survey and return in the envelope provided.

Customer Bill Of Rights

AS AN ARISTACARE PATIENT, YOU HAVE THE RIGHT TO:

1. Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care.

2. Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible.

3. Receive information about the scope of services that the organization will provide and specific limitations on those services.

4. Participate in the development and periodic revision of the plan of care.

5. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.

6. Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable.

7. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality.

8. Be able to identify visiting personnel members through proper identification.

9. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property.

10. Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal.

11. Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated.

12. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information.

13. Be advised on agency's policies and procedures regarding the disclosure of clinical records.

14. Choose a health care provider, including choosing an attending physician, if applicable.

15. Receive appropriate care without discrimination in accordance with physician orders, if applicable.

16. Be informed of any financial benefits when referred to an organization.

17. Be fully informed of one's responsibilities.

Customer Bill of Responsibilities

As an AristaCare Pharmacy patient, you have the responsibility to:

1. Provide true and accurate information at all times to the organization
2. While on service you must remain under a physician's care.
3. Inform the organization of any change in:
   - Address
   - Phone number
   - Emergency contacts
   - Primary caregiver
   - Insurance
   - Medical provider
   - If you are hospitalized
   - If you are unable to keep an appointment

4. Follow directions regarding medication administration, storage and delivery.
5. Contact the organization when you have any questions or problems with our equipment or medication
6. Ask for clarification to any service questions you may have.
7. Follow instructions, rules and regulations. Be an active and compliant participant in your Plan of Care and accept consequences if you do not.
8. Meet any financial commitments agreed to with the Company.

Notice of Privacy Practices

Effective Date: Throughout Care with AristaCare Pharmacy
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health care professionals who may provide treatment or consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example: your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEATH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of AristaCare. For example: information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to public health agencies as required by law to support government audits and inspections, to facilitate law-enforcement investigations and to comply with the government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For Example: pharmacies are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION. Disclosures of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocations of the authorization. However your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

EQUIPMENT AND/OR SUPPLIES: Your health information will be used by our staff to send you equipment and/or supplies reminders.

If you have any questions regarding this Notice of Privacy Practice, you may contact our Compliance officer at the AristaCare Pharmacy office.

CMS MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This list is an abbreviated version of the supplier standards, every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57 (c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care program, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet contain space for storing records.
8. A supplier must permit CMS, or it agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufacturers its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.

CONTINUED

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.

13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.

14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.

17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.

18. A supplier must not convert or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). Implemented Date – October 1, 2009

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57©. Implementation date –May 4, 2009.

27. A supplier must obtain oxygen from a state-licensed oxygen supplier

28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).

29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.

30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

PROBLEM SOLVING

Our goal is to assist you in returning to your maximum level of functioning and to provide all services possible to help you stay at home and be in your usual and customary surroundings. We are committed to ensuring that your rights are protected. If you feel that our staff has failed to follow our policies, or has in any way denied you your rights, please notify us immediately at AristaCare Pharmacy: 1-844-376-2784. All complaints and/or concerns will be reported to Pharmacy Management immediately, or the next business day if received after hours. We are committed to investigating and resolving all complaints and concerns within 72 hours of receipt of the report.

AristaCare Pharmacy
1056 West Golf Road,
Hoffman Estates, IL 60169
1 (844) 376-2784

If you choose to go directly to one of the following organizations,
please see contact information below.

Accreditation Commission for Health Care
(www.achc.org)
139 Weston Oaks Ct
Cary, NC 27513
855-937-2242

Medicare - CMS
www.medicare.gov
www.medicare.gov/claims-and-appeals/file-a-complaint/
www.cms.gov
Medicare Service Center: 800-MEDICARE (800-633-4227)

ADVANCE DIRECTIVES

You have the right to make choices about your health care. Please review the information below to learn how you can make choices regarding your health care.

ADVANCE DIRECTIVES: If you are ever unable to make your own health care choices or to communicate what you want to do, other people will have to make choices for you. Advance Directives are a way to let your family, friends and health care providers know your wishes to receive/or not to receive medical care and treatment. Advance directives protects your rights and gives you the power to make your own choices regarding your care.

It is important to have your advance directives in writing to ensure your family, friends and health care providers understand your choices. The two (2) common types of advance directives are living will and durable power of attorney for health care. These are legal pieces of paper that allow you to document your wishes.

LIVING WILL: Explains your wishes about health care and treatments. It is used only if you become terminally ill, if you are in an accident and have permanent brain damage, or if you are in a permanent unconscious state (coma).

DURABLE POWER OF ATTORNEY FOR HEALTH CARE: Names another person to make choices for you if you cannot make choices for yourself. The person is referred to as your agent or proxy. It is recommended to name a second person to make decisions for you in case your first choice is unavailable. The agent/proxy should be someone that you trust and you should discuss your wishes and choices regarding your health care and treatment.

To ensure your choices are clearly known, it is best to document them. You should be as clear as possible so that your wishes are clearly understood. Your advance directives can be changed or canceled at any time by you.

Sign your name and date the advance directives. It is best to have this done in front of a notary public. Please provide AristaCare a copy of your documents. We also recommend you give a copy to your doctor to put in your medical file.

PATIENT TIPS FOR INFECTION PREVENTION

WHAT IS INFECTION?

Infections are illnesses caused by germs. Germs are everywhere and most of the time do not make us sick. Our bodies have natural defenses like our skin and immune system that help protect us from germs. However, there are times when we can become infected, or sick from germs. Infection occurs when your body comes in contact with a germ it is not able to fight naturally.

TIPS FOR PREVENTING INFECTION AND STAYING HEALTHY:

KEEP YOUR HANDS CLEAN. Washing your hands regularly is the most important thing you can do to prevent infection. You should wash your hands after using the restroom, before you eat or handle food or when you have been in contact with items that could possibly contain germs, for example, after touching the handle of a grocery store cart. It is best to use soap and water to clean your hands, but hand sanitizer is a good alternative to keep your hands clean. Hand washing technique is very important when you are preparing your IV medication. See the next page for step-by-step instructions.

SNEEZES OR COUGHS. Infection occurs when germs enter our body - usually through our mouth or nose. If possible, avoid contact with others who are sick. If your doctor has prescribed a medicine that increases your risk of infection, it is important to avoid places where there are crowds. If you get an infection while on IV therapy, please contact us, this is especially important if you are on a medication which may increase your risk of infection.

COVER YOUR NOSE AND MOUTH IF YOU COUGH OR SNEEZE. Use a tissue or even bend of your elbow to prevent spreading germs to others. Remember to wash your hands afterwards.

KEEP YOUR SKIN HEALTHY. Take care of all cuts, scrapes and wounds. Your skin provides protection against harmful bacteria. Keep all cuts, scrapes and wounds clean and protected with a clean, dry bandage. If cuts are not healing, notify your doctor. If your skin is dry or cracking, apply a moisturizing cream to keep skin soft and intact.

IF YOU HAVE A FEVER, NOTIFY YOUR DOCTOR IMMEDIATELY. If you have a temperature greater than 1.5 degrees above your basal (normal) temperature, you should notify AristaCare and/or your doctor immediately unless you have been instructed otherwise.

GUIDELINES FOR PROPER HAND WASHING

It Only Takes 30 Seconds!
To prevent an infection, WASH YOUR HANDS before and after every procedure!

- Use liquid soap
- Use warmest water tolerated
- Keep hands pointing downward so any germs run down/away from your hands.
- Wet hands thoroughly, then remove from running water
- Apply Soap and scrub for at least 30 seconds
- Rinse well under running water
- Dry hands using a clean cloth or disposable towel

Tip: Gather all supplies needed for IV therapy *before* you start hand washing. You want your hands to be as clean as possible at all times!

1. Prepare your area by first cleaning with a disinfectant the area you will use.
2. Assemble your supplies.
3. Using warm water and a liquid antiseptic soap wash hands and wrists making sure you clean between your fingers.
4. Thoroughly rinse your hands and shake off any excess water.
5. Dry hands using paper towels and use the paper towel to turn off the water.
6. Sanitize your hands with hand sanitizer.
7. Open required supplies and prepare your medication for administration.
8. Remember to use your alcohol pads to clean all your IV connections.

MEDICATION AND PATIENT SAFETY IN THE HOME

We at AristaCare are very interested in your safety and the safety of your medication(s) in your home.

If you are dependent on utilities (gas, phone, electricity) you should register as a high priority customer with each utility.

THE FOLLOWING SAFETY TIPS ARE OFFERED TO ASSIST YOU:

Whenever you receive a prescription from us, it will be labeled with storage conditions. When you receive your delivery you should unpack it as soon as possible. This allows you to:

- Make sure you have received everything you were expecting.
- Can put your medication away immediately (if refrigerated, place in refrigerator)
- Identify any problems or concerns promptly. If you do have any concerns with your delivery contact us immediately.

SLIPS AND FALLS

Slips and falls are a primary concern for anyone in their home. When administering medications in the home, these are a greater concern since you may have tubing and a pump for your infusion on an IV pole. Some things you can do to make your home safer for you are:

- Arrange furniture to provide maneuverable pathways
- Keep stairs clear and well lighted
- Remove any throw rugs
- Wipe up any spills as soon as possible

ELECTRICAL ACCIDENTS

While on home IV therapy you may need to plug your pump into an electrical outlet to allow it to charge. Some things you should consider:

- Only plug your pump into a grounded outlet.
- Limit the use of extension cords
- Keep cords and electrical appliances away from water
- If you have a broken plug, outlet or wire, don’t use it or try to get it fixed

MEDICATION AND PATIENT SAFETY IN THE HOME (continued)

SMELL GAS?

- Open windows and doors
- Shut off any appliances that could be associated with the gas leak
- Contact your gas company to report the potential gas leak
- Do not use anything that involves an open flame

NEEDLE STICKS

Many therapies now use needleless connections for IV medications in order to reduce the risk of a needle stick injury. There are some medications that are given by injections and require a needle or you may need to add something to an IV medication bag like adding multivitamins to a parenteral nutrition bag, so the risk of a needle stick is still possible.

When handling a needle, the cap from the needle should not be removed until you are ready to administer the medication (either to yourself, a patient or added to a bag). After the injection you should not recap the needle.

SHARPS DISPOSAL

You should not throw your needle into your trash. In an effort to decrease community exposure to needles the Environmental protection agency (EPA) discourages patient from:

- Throwing needles into their garbage
- Flushing used needles down the toilet
- Placing needles in recycling containers

In order to assist you in properly disposing of your used needles, AristaCare will provide you with a sharps container. This is a specially made red plastic box designed exclusively for the disposal of used needles. After your injection, throw only the syringe and needle into the container after use. When your sharps container is 2/3-3/4 full, contact us and we will provide you a new sharps container and directions for disposing of the full one. You should never stick your hand into the sharps container.

MEDICATION SAFETY

Medication/Treatments and services are ordered by and given under the general supervision of your attending physician. Your medication and the solutions will be delivered to you in individual dosage units. Please be certain to read and follow all label directions carefully. Make sure the label contains the correct customer name, dose and date.

- Do not take medications that are prescribed for someone else.
- Create a complete list of current medications and keep the list with you at all times in the event of an emergency situation. Please make sure your nurse and pharmacist have a copy of this list and please make sure to provide them an updated list if you change any medications.
- Take medications as instructed. If the medication looks different than what you expected, ask your health care provider or pharmacist about it.
- Federal disposal guidelines for medications. Please follow any specific disposal instructions on the prescription drug labeling or patient information insert. Please ask your pharmacist if you have questions.

MEDICATION STORAGE

Store medications as directed on their labels in a clean, dry area out of the reach of children. If available, use a thermometer to check the operation temperature of the refrigerator.

Room Temperature: 20° C to 25° C (68° F to 77° F)
Refrigerated: 2° C to 8° C (36° F to 46° F)
Frozen: -25° C to -10° C (-13° F to 14° F)

- Refrigerated doses should be stored in an area separated from food. Remove doses from the refrigerator approximately on hour prior to infusion, or as directed on the label, and allow to stand at room temperature.
- Frozen bags should be thawed at room temperature. Frozen syringes may be thawed by rolling between the hands or by allowing to stand at room temperature. Never thaw frozen medications in the microwave.
- Inspect all medication doses before use for visible signs of contamination such as cracks, chips, tears cloudiness, discoloration, leaks, damaged caps or solids floating in the solution.

If you find any of these situations, notify your infusion pharmacist at the appropriate number on the back of this booklet.

It is important that you pay attention to the expiration dates on medication labels. Use all medications on a first-in-first-out basis (use up the supply on hand first unless the dose has changed). A drug sheet for each medication will be provided to you.

MEDICATION EQUIPMENT SAFETY (continued)

- Keep phone numbers available in the home so that you can notify the company and obtain necessary assistance if you are having problems with the equipment.
- Assure properly functioning electrical outlets are available for equipment, such as a stationary infusion pump that requires charging along with home medical equipment.

DELIVERIES

Deliveries are coordinated around medication stability, laboratory results and physician orders. Supplies are delivered by a delivery service or by an overnight service. It is a good idea to set a day and time each week to review your supplies and make a list of the items that you will need, as well as when you will need them. Your initial delivery ticket names the supplies and amounts that you will need. You can use it as a guide for reordering. Be ready to tell the representative how many of each item you are using each day or each week. Your insurance company will pay for supplies according to what is required to meet your care needs. We are committed to making sure you have enough supplies so we will send a few extra supplies as "safety stock" at no additional expense.

- Please call if you run low or out of supplies or medication sooner than expected.
- Please call if you have missed a dose and/or your delivery has not arrived as scheduled.
- Federal law prohibits the return of unused medical supplies and drugs, so be sure to order only what is needed.

Staff from AristaCare will call you to arrange for your next delivery. You can plan to receive a weekly call from our staff to discuss supplies, to assess how the therapy is going along with scheduling your next delivery. It is important that we are able to get a hold of you to review these items prior to every delivery. Please call us if your supply needs change, if your therapy changes or if you are hospitalized. If you have any questions on your supplies, please do not hesitate to call us. It is important to return your rental equipment within the first two days of completion of therapy or in the event that you are hospitalized. We will work with you in arranging either a courier pick up or a FedEx return box. It is important to work with AristaCare staff in getting the pump returned timely. In the event that the pump is not returned within a week upon dismissal of the therapy and/or the pump is returned damaged, the patient will incur the responsibility to purchase a new pump or pay for the repair of the damaged pump. If the return box is to be used, it will be sent to you on initial delivery and we recommend you store it in a safe place until completion of the use of the equipment. Directions on how to return the box will be attached to the box at delivery.

SUPPLIES

We have taken care to package all that you will need to get started. Although your initial supply order may seem like it contains more items than you will need, keep in mind that it may include some reserve or emergency supplies. It is important that you always keep a small amount of reserve supplies on hand in case a delivery is delayed. Your nurse can help you set aside the appropriate supplies you may need for reserve.

EMERGENCY PREPAREDNESS

WEATHER CONDITIONS:

In the event of inclement weather, we will follow these guidelines regarding travel during the snow and ice season along with any additional seasonal weather that surfaces. Every effort will be made to provide services to you based on your needs and the urgency of the request. Our organization watches weather forecasts on an ongoing basis and plans ahead accordingly.

POWER OUTAGE:

If you need help in a power outage and our phone lines are down:

- Call 911 or go to the emergency room if you have an emergency
- Call your closest relative or neighbor if it is not an emergency

FIRE SAFETY:

Develop a fire plan for your home and include what you would do with the medications, supplies and equipment. Some things you can do are:

- Install smoke detectors, if smoke detectors are in place make sure the batteries work
- If oxygen is in use, make sure there is a non-smoking sign visible to all
- Do not put any matches into a waste container
- Keep your chimney clean if applicable
- Never leave any appliance on unsupervised
- Have a fire extinguisher and make sure it is not expired

IF YOU HAVE A FIRE OR SUSPECT FIRE:

- Take immediate action per plan – Escape is your top priority
- Call 911 to get help on the way
- If your fire exit is cut off close the door and seal any cracks to hold back smoke and signal for help from the window

IN AN EMERGENCY SITUATION, KEY ITEMS TO NOTE:

- In the case of a medical emergency, please dial **911**
- If your local AristaCare location can not be reached at **844.376.2784**, please call our Sister AristaCare location at **888.860.8806** who can assist you.
- If you have missed your delivery, please contact the main AristaCare number at: **844.376.2784**
- In the event you have challenges with the equipment for your infusion needs, please call us at **844.376.2784**.
- If your delivery location has changed, please notify us and update us.
- If you need to provide additional phone numbers for AristaCare to be able to reach you, please call us and provide the update.

DISASTER PREPAREDNESS

Regardless of the type of disaster, if you have to evacuate, PLEASE call us as soon as possible so we can ensure you have the medication and supplies you need.

NATURAL DISASTER OR SEVERE WEATHER:

- Listen to your local radio stations for weather condition updates. Follow any advice provided by the news (Tornado, go to an interior room with no windows or a basement, etc.)
- Have a list of emergency services (fire, police, ambulance, health care provider, etc.) available
- Have an emergency kit (water, a 3 day supply of your supplies, flashlight, hand sanitizer, candles, matches, batteries, blankets, etc.) and know where it is located so that if you need it you can find it.
- If you have to evacuate, inform the shelter of any special needs you have.

MEDICAL EMERGENCY

- Attempt to contact local emergency services and 911
- Contact AristaCare so, if necessary, we can assist emergency services or the hospital
- If appropriate call Poison Control

PATIENT TRAVEL ASSISTANCE

One of the benefits of home infusion therapy is the increased mobility and freedom you gain as a patient. This includes the ability to travel away from home, either on business or for vacation. If you are traveling away from your home, AristaCare can provide assistance in arranging for your medical needs. We can arrange services on your behalf at your destination. **Please allow a minimum of two weeks' advance notification prior to your departure date so that we can make the appropriate arrangements.** Early planning and careful preparation is essential to a safe and enjoyable trip. We encourage you to be actively involved in your travel arrangements. Thank you for your cooperation in helping us to help you.

NOTES

CUSTOMER AGREEMENT AND INFORMED CONSENT

Patient Name: ______________________ DOB: ________________ Date of Initial Therapy: __________________

Consent for Treatment

I hereby authorize AristaCare Pharmacy to provide products, supplies and services as prescribed by my health care provider. I confirm I have been informed and have participated in planning my care and any procedures to be carried out by the agency and sign this consent willingly and voluntarily. I understand this consent is valid from the date of the initial therapy and I may withdraw my consent at any time by notice to the agency and, if I do so, the services thereafter will not be provided.

Assignment of Insurance Benefits

I hereby assign and transfer to AristaCare any and all rights to receive payment of insurance benefits. The assignment of benefits includes pharmaceuticals, durable medical equipment and, if applicable, home health care, nursing and surgical benefits which are otherwise payable to me for products or services provided. This assignment covers all benefits under Medicare, other state and federal government- sponsored programs, private insurance and any other healthcare plans. I understand this document constitutes a legally binding assessment, and is not a mere authorization to collect benefits on my behalf. I also authorize and direct my insurance carrier(s) to furnish an agent of AristaCare any and all information pertaining to my insurance benefits and the status of claims submitted by AristaCare for services rendered. I understand payments may be sent by my insurance provider directly to me. I agree when such payments are received, I will promptly submit them to AristaCare for payment of my bill. I can make payment by personal check or endorsement of the insurance payment by writing “Pay to the order of AristaCare” and my signature. I understand I am also responsible for copayments, deductibles and services not otherwise covered by my insurance carrier.

Payment of Services Rendered

I understand I am the responsible party for all medications and services rendered by AristaCare. I understand it is my responsibility to notify AristaCare of my insurance information, including prescription card information. I understand it is my responsibility to notify AristaCare of any changes in my insurance coverage. I understand it is my responsibility to pay for any medications and services rendered which are not covered or are rejected by my insurance carrier, for whatever stated reason.

Insurance Company Name: ____ Deductible: ________________ Met: _________________
Out-of-Pocket: _____________ Met: ____________ Co-Insurance: ________ /_________ Patient Daily Est. Cost: __________________
Secondary Insurance Company Name: _________________________________ Deductible: _____________ Met: ________________
Out-of-Pocket: _____________ Met: ____________ Co-Insurance: ________ /_________
Pharmacy Benefit Manager Name: ____ Patient Co-Pay Amount: __________________

Patient Release of Information

I understand AristaCare will be providing me with pharmacy services to help me improve and maintain my health. AristaCare will provide health-related information about me and the services I receive to my physicians and other health care professionals involved in my care as to keep them informed of my progress. I understand AristaCare will provide information necessary for billing to my insurance company. I hereby authorize AristaCare to release all information and records related to the care I receive to my physician, insurance company and any other health care professional involved in my care. I hereby authorize the release of all pertinent medical information to AristaCare. I hereby release AristaCare, their affiliates, directors, employees, successors and assign from any and all liability arising from or in any way connected with the release of such information. I authorize AristaCare to discuss my medical condition/care with the following individuals:

Name: ____ Relationship: ___________________________________
Name: ____ Relationship: ___________________________________

Acknowledgment of Receipt of Notice of Privacy Practices and Mandated Forms

I hereby acknowledge receipt of the Notice of Privacy Practice concerning Protected Health Information (PHI) from AristaCare as they relate to the Health Insurance and Portability and Accountability Act of 1996 (HIPAA). I hereby acknowledge receipt of Client Bill of Rights, receipt of medication refill and shipment process, receipt of infection control procedures and receipt of procedure for filing a grievance or complaint. I hereby acknowledge receipt of the DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) Supplier Standards and Medicare.

Returned Goods

I understand that due to Federal and State Pharmacy Regulations ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Home Infusion Equipment that is rented will be returned after the physician has discontinued service. Sale items cannot be returned. AristaCare must be notified within 24 hours of the set-up if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item. Rental equipment must be returned within the first two days of therapy completion or in the event of hospitalization. If the pump is not returned within a week upon dismissal in working order, I understand I will incur the responsibility to purchase the pump at the cost of a new pump.

Patient Handouts

I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPAA Privacy Standards, Emergency Planning, and Advance Directive Information. I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish AristaCare with a copy of such document.

Problem Solving:

I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any Portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 1-844-376-2784 and speak to the Pharmacy Management. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

Prescription Drug Coverage and Rights as a Medicare Beneficiary

AristaCare will provide products and/or services agreed upon at order coordination to the stated patient. The estimated cost of each treatment will be communicated at time of order coordination. I understand the amount may vary depending on deductible and out of pocket expenses. I agree to make payment arrangements at the time of order coordination. A Medicare ABN will be issued if needed.
I agree to the terms stated in the AristaCare Customer Agreement and Informed Consent.

Patient Signature (or Representative): ____ Date: __________________
Relationship of Representative to Patient: ____ Is patient a minor? Yes / No

BENEFIT NOTIFICATION / AOB

Based on benefits as of: ________________

Patient Name: ______________________ Therapy: ______________________

☐ **INSURANCE PLAN** Insurance: ______________________

I have commercial insurance and have authorized payments to AristaCare in accordance with the Assignment of Benefits that I have executed. Any payment made to me will be forwarded to AristaCare upon receipt. I will pay all applicable charges not paid by my insurance as billed by AristaCare .

Deductible Amt.: __________ Amt. Met: __________ Coverage Once Met: __________ ☐ Calendar Year

Out of Pocket: __________ Amt. Met: __________ Coverage Once Met: __________ ☐ Benefit Year

☐ Authorization Complete ☐ Authorization Pending ☐ Authorization Not Required

My responsibility will be any remaining deductible, then ______ % of the charges until the Out of Pocket.

______ % is approximately: $ __________ Yearly Max: __________ Lifetime Max: __________

☐ Your medication will be covered by your prescription drug plan with a copay of: $ __________

☐ **MEDICARE** ☐ Part A ☐ Part B ☐ Part D

I have Medicare coverage and have authorized payment to AristaCare in accordance with the Assignment of Benefits that I have executed. Medicare Advanced Beneficiary Notification (waiver) may be applicable.

Total Deductible: __________ ☐ Met ☐ Not Met Estimated Co-Pay Responsibility: __________

☐ Medicare does not pay for this equipment/supply for your condition.

Medicare Part D Specific:
I understand that when my "True Out of Pocket" drug cost reach ______ I will be 100 % responsible for all of my drug until such time as I qualify for catastrophic Medicare Part D coverage ($4,700) at which time I will be responsible for ______ % of my drug costs.

☐ **MEDICAID** Medicaid #: ______________________

I have Medicaid. My financial responsibility is $0.00 for **Medicaid Covered Services**, unless I am responsible for a spend-down of $ ______. If I have a Medicaid pending and my application is denied or I am not eligible on any date of service, I will assume financial responsibility for all charges. I agree to make payment in full within ______ day(s) of my first delivery.

Eligible State: __________ HMO Plan: ______________________

Medicaid RX Co-Pay Amt.: __________

☐ **PRIVATE PAY, NO INSURANCE COVERAGE** The cost of your therapy will be: __________ Per: __________

____

Based upon the treatment currently ordered by your physician. Should your medication orders change or a new therapy start (including IV line care after medication discontinues), a price will need to be discussed. Based on this information and a discussion with you, the following terms will be extended.

☐ I will pay total due. ☐ I will pay $ ______ on initial delivery. ☐ I will pay $ ______

☐ **UNVERIFIED**

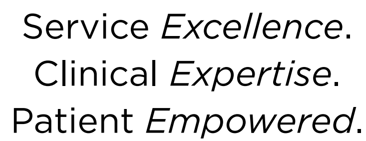
I have insurance and have assigned benefits to AristaCare . I agree to pay for all medications, supplies, equipment, and nursing services provided until such coverage can be verified.

This is a contract between you and AristaCare **. Should your Insurance change, expired, or not pay for any other reason, you must understand that you will be responsible for 100% of charges.**

Patient Signature / Responsible Party ______________________ Date Signed: __________

IMPORTANT PHONE NUMBERS	
Ambulance: **911**	Pharmacy: **1-844-376-2784**
Fire: **911**	Home Health Care:
Police: **911**	Family:
Poison Control: **1-800-222-1222** OR **911**	Water Company:
Doctor:	Telephone Company:
Hospital:	Electric Company:

OTHER	



For Additional Information, Visit:
aristacarehealth.com
Toll-Free: 1.844.376.2784

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