

To our new patient,

Welcome to the AcariaHealth[™] family of pharmacies. Our team of highly skilled and caring health care professionals are working together to meet your needs. Our licensed specialty pharmacies will deliver your medications directly to your home, and we have clinical pharmacists available 24 hours a day, 7 days a week to discuss your therapy and answer any questions you may have regarding your medications and supplies. Our team also speaks multiple languages, to best serve you.

Keep in mind that frequent and open communications between you, your physician, your nurse and your pharmacist are important to the success of your therapy. AcariaHealth will be sending medications and supplies to you on a frequent basis, depending on which medications you are taking, so it is important that you communicate with us if you run low on supplies between deliveries or have any other medication or supply problems.

AcariaHealth offers clinical programs to all patients. These programs help ensure safe and appropriate medication use. Our clinical programs are designed to help you manage side effects, improve your overall health, increase your disease and medication education and awareness and increase medication compliance. Also, if coordination of care with your physician is necessary, your pharmacist will have all the information needed to help make informed decisions regarding what is best for you. You must be willing to follow the directions of your physician and pharmacist, be compliant with taking your medication and willing to discuss the details of your disease, medical history and current practices with your pharmacist so he can have a full understanding of the situation.

AcariaHealth provides patient-specific, evidence-based health information about your condition, diagnosis and treatment plan, and we can also provide additional education sources, such as websites, counseling groups, and other providers that may be beneficial to you upon your request.

The prescription order we are providing to you today was prepared with great care by a team of knowledgeable pharmacists practicing in the AcariaHealth network of specialty pharmacies. Some of the processing of your prescription may have been performed by a licensed pharmacist in one of our pharmacies in a state other than where your prescription was actually dispensed.

These centralized processing duties are performed remotely via a secured electronic means and include activities, such as reviewing prescriptions for accuracy, appropriateness, checking for drug interactions, and other professional reviews. However, the final check of and the dispensing of your prescription order was performed by the pharmacist located at the address shown on your prescription label.

If you have any questions or concerns regarding this notification or any of our services, please don't hesitate to contact us by calling toll free at 800.511.5144. We are here for you, and look forward to serving you!

Sincerely,
Your AcariaHealth Team

**Accessible formats and communication supports are available, upon request.*

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AcariaHealth Vision, Mission and Core Values

CARING

Caring is the heart of everything we do. Caring motivates our work. We care about our teammates, our patients and our healthcare partners. Caring is the underpinning of our business philosophy, that doing the right thing leads to requisite rewards for everyone.

OUR VISION

AcariaHealth combines leading specialty pharmacy expertise with a focus on results and caring service, which benefits plan sponsors, patients, and the greater community.

OUR MISSION

AcariaHealth transforms the specialty pharmacy experience with innovative and flexible solutions, clinically driven programs and data analytics that lead to the best and most cost-effective outcomes for patients.

CORE VALUES

1. Be driven by caring

Caring is at the heart of everything we do and doing the right thing rewards everyone.

2. Live open, honest, accountable lives

We believe in transparency in who we are and how we serve our clients. Integrity and financial performance are inseparable.

3. Exceed expectations; be passionate

We strive to exceed expectations every day. We combine a passion for improving lives with unrivaled expertise to drive results for all.

4. Embrace creativity and dare to be different

We have an independent spirit which gives rise to creative clinical and business solutions, a competitive edge and a strong desire to make a difference.

5. Be humble

Our humble disposition powers our service culture. We promise customized, one-to-one interaction from our team.

6. Pursue excellence with urgency

We work with a sharp sense of urgency and believe our work has an important bearing on the patients we serve.

7. Reinvent fun; smile

We are a diverse and friendly team with positive attitudes. We come to work excited and empowered to make a difference.

8. Focus on the patient; all else will follow

Everything we do is built around the patient. This leads to a positive and measurable difference and ultimately drives the success of our company.

9. Value the perspectives and differences in others

We are motivated by natural curiosity. We support the differences people bring to life because it makes us and our work stronger.

10. Tackle all jobs big and small

We believe in teamwork. We take an all-hands-on-deck approach to everything we do.

Emergency Management Plan

We are prepared to handle emergencies/natural disasters. In case of severe weather or other disaster, our pharmacies work to ensure you receive your prescription on time. Every effort is made to coordinate care with local healthcare agencies, when needed.

AcariaHealth's procedures for ensuring continuity of care in the event of a disaster include:

- > We have plans for meeting your immediate needs, and/or discuss the date the service will be reinstated.
- > In the event our pharmacy location is forced to close down as a result of an emergency, your services will be coordinated with an alternate AcariaHealth branch or subcontracted pharmacy.
- > If we are unable to deliver your medication on time, we will contact you. We will work with you and your physician to locate the pharmacy closest to you and arrange to have it filled at that pharmacy, if necessary.

If you have an immediate need for medication, we will supply your needs on a priority basis. We will provide you with enough supply to get through the emergency, whenever possible.

If an emergency occurs and we are unable to reach you, and you are experiencing difficulties administering or obtaining your medication, please go to the nearest emergency room for help. In order to make sure an emergency does not negatively impact your prescription needs, you should take the following precautionary measures:

- > Whenever possible, keep a two- to three-day supply of your medication on hand and a back-up power supply for your medical equipment and/or supplies.
- > Make sure we have accurate contact information, including your emergency contacts.
- > In case of an emergency, seek medical attention at an area hospital or by calling 9-1-1.

Remember that preparation is key when facing emergencies – please be safe.

Best Practices for Administering Medications & Handling Supplies

Below are best practices and techniques for administering your medications and handling your supplies.

AcariaHealth will assist you with monitoring all items ordered by your physician and ensure that you have enough supplies to administer your therapy. We will work with you to arrange a delivery time and deliver all supplies will be sent to your home. It is important that you:

- > Use the medications you have on-hand before using newly-delivered ones, unless your physician changes the prescription.
- > Check the expiration date on all supplies and/or solutions before using. If the date has passed, *DO NOT USE* that item and call AcariaHealth.
- > *ALWAYS* wash your hands before handling supplies and solutions.
- > Check your supply inventory periodically to enable us to deliver additional supplies.

So that we can provide the best service, please let us know immediately if any of the following occur:

1. Your physician adds or deletes any of the items on your prescription, or changes the usage of any of the products.
2. The items delivered are damaged.
3. You are unable to take inventory of your supplies as scheduled.
4. Your physician discontinues your treatment, or you are hospitalized.
5. You discovered an error in the shipment so that we may correct the mistake.

CARE AND STORAGE

Some of the medications and supplies you will use must be stored in a refrigerator, while others can be kept in a clean, dry storage area. If you were told, or if the label or directions say *REFRIGERATE*, you must:

1. Keep your refrigerator temperature between 40 – 45 degrees° F.
2. Always keep supplies on a separate, dry shelf or in a bin, *NOT* with food supplies.
3. Always check the label on medications for the proper name, dosage and expiration date.
4. Inspect medications before administration. If you notice undissolved particles and unusual color, leakage or any other uncommon occurrences, *DO NOT USE THE MEDICATION*.

PRINCIPLES OF ASEPTIC TECHNIQUE

Aseptic technique is a way to perform a task that will keep germs that are normally found on the human body from contaminating your supplies and from possibly causing an infection.

1. Perform all “dirty” handling operations (i.e. opening shipping cartons, cleaning work space, etc.) prior to washing hands.

Continued on back

2. Before setting up all supplies necessary to administer your therapy, your workspace should be wiped down with soap and water, and then with isopropyl alcohol. Allow to air dry.
3. Wash your hands using the appropriate technique (see “Hand Washing” section below).
4. Do not sneeze or cough directly over your equipment, supplies, or solution.
5. Clean rubber stoppers with isopropyl alcohol wipes. Allow to air dry.
6. Do not touch sterile surfaces of needles, syringes, etc., with your fingers, clothing, or other objects. If you accidentally contaminate any supplies, do not use them. Open a new package.
7. Work in a room free of drafty air.
8. Plan ahead to avoid interruptions.
9. Discard any supplies you feel may have been contaminated.

HAND WASHING

Your hands contain many germs. By using good hand-washing technique you can decrease the number of germs on your hands. Wash your hands thoroughly before every procedure and as often as needed.

1. Remove all jewelry before washing. Germs can be under these items.
2. Adjust water temperature and keep water running while washing and drying hands.
3. Wash your hands with soap and water for at least one minute. Be sure to scrub all surfaces of your hands, starting from your fingernails to your wrists, paying especially close attention to cleaning under your fingernails.
4. Rinse skin thoroughly to remove all soap.
5. Keep fingers higher than wrists to allow water to drain away from fingertips.
6. Dry hands completely with a clean, dry paper towel.
7. Use paper towels to turn off water. Dispose of towels.

HANDLING OF SHARPS AND BIOMEDICAL WASTE

Biomedical waste includes used needles and syringes. Biomedical waste *MUST* be properly disposed of. AcariaHealth will supply you with the necessary containers for biomedical waste disposal.

1. Needles should only be used once.
2. Needles should be discarded without attempting to replace the protective cover.
3. Never overfill disposal (“sharps”) containers. Contact AcariaHealth for a new container.
4. Never put a sharps container in your trash. Refer to the “Sharps Disposal Information” instructions provided in your admissions packet.
5. Do not share your needles.
6. Exposed needles should not be left unattended.
7. Keep the sharps container out of children’s reach.

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SHARPS-tainer (stackables) Instructions for Use and Disposal

Note: Post these instructions near the point of use.

CAUTIONS

1. Inspect sharps container before use for cracks or damage, then assemble lid according to Lid Assembly instructions.
2. Store container out of traffic areas in order to minimize possibility of container being knocked over.
3. **DO NOT** under any circumstances insert hand or object into sharps container.
4. **DO NOT COMPACT CONTENTS OF CONTAINER OR FORCE SHARPS INTO CONTAINER.** When contents have reached recommended fill line (approximately $\frac{3}{4}$ full), the container must be disposed of and replaced. **DO NOT OVERFILL.**
5. Follow Final Closing and Disposal instructions when container is full.

LID ASSEMBLY INSTRUCTIONS

1. Place lid onto the container before placing any sharps (used syringes/needles) into the container.
2. Make sure the lid is securely on the container by pressing firmly around edges of lid to ensure snap features are fully engaged on container. Listen for clicks. This is for your safety.
3. Now the sharps container is ready for use. Open lid and place sharps into receptacle opening.

FINAL CLOSING INSTRUCTIONS

Once fill level has been reached and sharps container is ready for final disposal:

1. Fold down the permanent locking tabs (if applicable) which are located at the front of the lid opening.
2. Close lid and engage the tabs into the slots provided. For the sliding door design, use the handle to slide the door past the locking posts.
3. Press firmly until a snap is heard for each tab, for all designs except the sliding door. Do not press on the middle of lid or door when closing.
4. Fold tab down and insert into slot, if container is equipped with round trap. Now the sharps container is ready for disposal.

DISPOSAL INSTRUCTIONS

1. Dispose of contaminated sharps containers in compliance with national, state and local regulations and in accordance with institutional policy. You must be in compliance with all regulations and policies.
2. Inspect prior to moving to ensure that no sharps are protruding from container.
3. Contact the local Environmental Protection Agency (EPA) in your area for guidance on waste disposal if container is equipped with round trap.

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How to Dispose of Medicines Properly

Medications are important for treating many conditions and diseases, however they may be harmful if taken by someone that does not need them. To avoid accidental exposure or intentional misuse of prescription and over-the-counter drugs it is important you dispose of them properly.

DON'T: Flush expired or unwanted medications down the toilet or drain unless the label specifically instructs you to do so.

DO: Return unwanted or expired medications to a drug take-back program or follow the steps for household disposal below.

HOW TO DISPOSE OF MEDICATIONS?

Drug Take-Back Events

The preferred way to dispose of unwanted medications is through a local take-back program. For more information call your city or county government's household trash and recycling service and ask if a drug take-back program is available in your community. Some counties hold household hazardous waste collection days, where prescription and over-the-counter drugs are accepted at a central location for proper disposal.

Household Disposal Steps*

If no disposal instructions are provided on the medication's label and no drug take-back program is available in your area, follow the recommended steps below to safely dispose of your medication:

1. Take your medications out of their original containers.
2. Mix drugs with an undesirable substance, such as dirt, cat litter or used coffee grounds.
3. Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a sealable bag.
4. Remove any personal information from the medication's original container, including Rx number, by covering it with permanent marker or duct tape, or by scratching it off.
5. The sealed container with the drug mixture, and the empty drug containers, can now be placed in the trash.

** Drug Disposal Guidelines, Office of National Drug Control Policy, October 2009*

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How Proper Disposal of Medicines Protects You and the Earth:

- > Prevents poisoning of children and pets.
- > Prevents misuse by teenagers and adults.
- > Avoids health problems from accidentally taking the wrong medicine, too much of the same medicine, or a medicine that is too old to work well.
- > Keeps medicines from entering streams and rivers when poured down the drain or flushed down the toilet.

How Improper Disposal of Medicines May End Up in Our Drinking Water Sources

In homes that use septic tanks, drugs flushed down the toilet can leach into the ground and seep into ground water.

In cities and towns where residences are connected to wastewater treatment plants, drugs poured down the sink or flushed down the toilet can pass through the treatment system and enter rivers and lakes. They may flow downstream to serve as sources for community drinking water supplies. Water treatment plants are generally not equipped to routinely remove medicines.

Information provided by the United States Environmental Protection Agency (EPA)

For more information go to www.epa.gov/ppcp/ or call the Safe Drinking Water Hotline at 800-426-4791

April 2011

Medicare Prescription Drug Coverage and Your Rights

YOUR MEDICARE RIGHTS

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an “exception”** if you believe:

- > You need a drug that is not on your drugplan’s list of covered drugs. The list of covered drugs is called a “formulary”
- > A coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- > You need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price

WHAT YOU NEED TO DO

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan’s toll-free phone number on the back of your plan membership card, or by going to your plan’s website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan’s notice will explain why coverage was denied and how to request an appeal if you disagree with the plan’s decision.

Refer to your plan materials or call 1-800-Medicare for more information.

MEDICARE SUPPLIER STANDARDS FOR MEDICARE PATIENTS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to be eligible to receive payment for a Medicare-covered item. 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 ensure accessibility for the disabled. A supplier must be licensed to provide certain items or services, but may also contract with another licensed individual or entity to provide those services unless expressly prohibited by State law.
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 programs, 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, 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 the location to be accessible to the public and staffed during posted hours of business. The location must be accessible to beneficiaries during reasonable business hours and must maintain a visible sign and posted hours of operation. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
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 manufactures 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.
12. A supplier must instruct beneficiaries on the use of Medicare-covered items, is responsible for item delivery and must maintain proof of delivery.

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13. A supplier must answer questions and respond to beneficiary complaints, and maintain documentation of such contracts.
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 convey 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 and be made available to CMS upon request.
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.
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. If new products are added after enrollment, supplier must notify their accrediting body for a re-survey and new accreditation.
26. A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
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.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

You have the right to:

- Considerate and respectful service. Obtain service without regard to race, creed, national origin, gender, sexual preference, age, disability or illness, or religious affiliation.
- Speak with a health care professional.
- Confidentiality of all information pertaining to you, your medical care, and service and to have personal health information shared in accordance with state and federal law.
- A timely response to your request for service and to expect continuity of services.
- Select the home medical equipment supplier of your choice.
- Be privy to information on your treatment outcomes.
- Make informed decisions regarding your care planning.
- Participate in decisions concerning the nature and purpose of any technical procedure that will be performed and who will perform it, the possible alternatives and/or risks involved, your right to refuse all or part of the services, and to be informed of expected consequences of any such action based on the current body of knowledge.
- Agree to or refuse any part of the plan of service or plan of care.
- Be told what service will be provided in your home, how often, and by whom.
- An explanation of charges including policy for payment.
- Voice grievances or complaints regarding treatment of care without fear of termination of service or other reprisals.
- Be treated with respect, consideration, and recognition of client/patient dignity and individuality.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown sources, and misappropriation of client/patient property.
- Have your communication needs met.
- Receive information about the philosophy and characteristics of AcariaHealth's patient management (clinical) programs, including administrative information regarding changes in or termination of the clinical program.
- Identify the staff member of the clinical program and their job title, and to speak with a supervisor of the staff member, if requested.
- Be referred to other health care providers, if desired, within an external health care system (ex. Dietician, pain specialist, mental health services, etc.). You may also be referred back to your own prescriber for follow up.
- Receive assistance with any eligible internal programs that help with patient management services, manufacturer copay and patient assistance programs, and health plan programs (tobacco cessation programs, disease management, pain management, and suicide prevention/behavioral health programs).
- Decline participation, revoke consent, or disenroll from the clinical program at any point in time without jeopardizing access to care, treatment, or other services being provided.

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You have the responsibility to:

- Provide accurate and complete information to AcariaHealth regarding your medical history and current condition, any payers which may cover your care, financial information, and to promptly inform AcariaHealth of changes in this information.
- Provide AcariaHealth with a guardian decision-maker if you are unable to make decisions regarding care, treatment, or services, in accordance with state and federal law, if you desire.
- Participate in planning, evaluation, and revising your care plan to the degree that you are able to do so. Adhere to the plan of care, which you participated in developing. Ask questions about any part of the plan of care that you do not understand.
- Ask AcariaHealth what to expect regarding pain and pain management, discuss pain relief options with them, work with them to develop a pain management plan, ask for pain relief when pain begins, help the AcariaHealth personnel assess your pain, tell them if your pain is not relieved, and tell them about any worries you have about taking pain medications.
- Arrange for supplies, equipment, medications, and other services, which AcariaHealth cannot provide, that are necessary for provision of care and your safety.
- Protect the equipment from fire, water, theft, or other damage while it is in your possession.
- Use the equipment for the purpose for which it was prescribed, following instructions provided for use, handling care, safety, and cleaning.
- Supply us with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered. You are responsible for settlement in full of your account.
- Be at home for scheduled service visits or notify us in advance to make other arrangements.
- Notify us immediately of:
 - Equipment failure, damage, or need of supplies.
 - Any change in your prescription or physician.
 - Any change or loss in insurance coverage.
 - Any change of address or telephone number, whether permanent or temporary.
 - Discontinued equipment or services.
- Contact us if you acquire an infectious disease during the time we provide services.
- Accept the consequences for any refusal of treatment or choice of noncompliance, including changes in reimbursement eligibility.
- Submit any forms that are necessary to participate in the clinical program, to the extent required by law.
- Give accurate clinical and contact information and to notify the clinical program of changes in this information.
- Notify your treating provider of your participation in the clinical program, if applicable.

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Dear Patient,

Welcome to AcariaHealth. Below you will find a list of forms that we request you complete and send back to us as soon as possible.

You may mail the documents to:

AcariaHealth
1311 W Sam Houston Pkwy N #130
Houston, TX 77043

Documents to be returned

- Acknowledgement of receipt of Notice of Privacy Practices**
This form confirms you've received the Notice of Privacy Practices which explains how your information is kept private.
- HIPAA Authorization for Use and Disclosure of Protected Health Information (PHI)**
This form allows you to tell us how we may use and share your health information. If you'd like to authorize someone to have access to your health information you must return this form.
- Assignment Agreement**
This is a consent form.
- Patient Drug Profile**
This form helps us understand your treatment.
- Delivery Ticket**
This ticket is sent with your medicine. Sign and return it once you have received your medicine.

We've also included a grievance form that you can use at any time to voice your concerns, grievances or file a complaint.

If you have any questions about the documents included in this package, please contact us.

Sincerely,

The AcariaHealth Team

Notice of Privacy Practices

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.

This Notice of Privacy Practices (“Notice”) covers an Affiliated Covered Entity (“ACE”). When this Notice refers to the AcariaHealth ACE, it is referring to AcariaHealth, Inc. (“AcariaHealth”) and each of the following AcariaHealth subsidiaries and affiliates: Specialty Therapeutic Care, LP, AcariaHealth Pharmacy, Inc., AcariaHealth Pharmacy #11, Inc., AcariaHealth Pharmacy #12, Inc., AcariaHealth Pharmacy #13, Inc., AcariaHealth Pharmacy #14, Inc., HomeScripts.com, LLC, and Foundation Care, LLC.

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 RESPONSIBILITY

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.

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 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 disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make).

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.
- > 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.
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.
- > Sharing of certain other sensitive health information as required by State laws.

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: An AcariaHealth Inc. pharmacist may discuss your prescription information with your doctor to ensure proper treatment.

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.

Respond to organ and tissue donation requests

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

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 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.

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

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.
- > We must provide you a copy of this notice.
- > 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/noticeapp.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.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

You may contact the Privacy Office by calling toll free 888.218.7954, via email at Privacy@AcariaHealth.com, or by writing to:

AcariaHealth, Inc.
Attn: Privacy Office
8427 South Park Circle, Suite 400
Orlando, FL 32819

Notice of Privacy Practices

ACARIAHEALTH ACE NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the AcariaHealth, Inc. and its affiliates and subsidiaries (collectively, the “AcariaHealth ACE”) Notice of Privacy Practices.

I acknowledge receipt of the *Notice of Privacy Practices* of the AcariaHealth ACE.

Patient Name: _____

Signature: _____ Date: _____

Print Name: _____

(Patient / Parent or Legal Representative)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed by AcariaHealth only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgement, describe the good faith efforts made to obtain the individual’s acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of AcariaHealth Provider Representative: _____ Date: _____

Reasons why the acknowledgement was not obtained:

_____ Patient Refused to Sign

_____ Other or Comments: _____

(ex: Delivery to patient’s home; patient was not able to sign.)

PLEASE RETURN THIS FORM USING THE ENVELOPE PROVIDED. SHOULD YOU DECIDE TO RETURN THE FORM AT A LATER DATE, YOU MAY MAIL IT TO:

AcariaHealth, Inc.
Privacy Office
8427 South Park Circle, Suite 400
Orlando, FL 32819

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The purpose of this HIPAA Authorization Form is to enable patients to authorize **AcariaHealth, Inc.**, to disclose their Protected Health Information (PHI) for certain purposes. Completing this form will allow AcariaHealth, Inc., to share your health information with the person or organization that you identify below. *You are not required to complete this form if you do not wish to make an Authorization.*

PATIENT INFORMATION		
Patient Name:	Date of Birth:	
Address:		
Email address:	Phone:	Last 4 digits of SSN:

1. I authorize AcariaHealth, Inc., and any of its affiliated covered entities¹ to release my personal health information maintained by AcariaHealth to:

[Insert full name of person or organization]

[Purpose of use/disclosure]

2. Information to be disclosed (*check all that apply*):

- ALL pharmacy related records, OR
- Pharmacy billing records
- Prescription records
- Progress notes
- Other _____

If applicable, I also give permission for the following to be disclosed (**please initial**):

_____ Pharmacy records related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

_____ Pharmacy records related to treatment for alcohol and/or drug abuse

¹ Affiliated covered entities include Specialty Therapeutic Care, LP, AcariaHealth Pharmacy, Inc., AcariaHealth Pharmacy #11, Inc., AcariaHealth Pharmacy #12, Inc., AcariaHealth Pharmacy #13, Inc., AcariaHealth Pharmacy #14, Inc., and HomeScripts.com, LLC,

3. Covering the periods of health care: FROM (date): _____ TO (date): _____
4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written request to **AcariaHealth, Inc., Attn: Privacy Officer, 8427 Southpark Circle, Suite 400, Orlando, FL 32819**, or **email to Privacy@AcariaHealth.com**. I understand that the request to revoke this Authorization will not apply to information already released in response to this authorization.
5. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . **If I fail to specify an expiration date, event or condition, THIS AUTHORIZATION WILL EXPIRE IN 12 MONTHS.**
6. I understand that this authorization is voluntary and treatment and/or payment for claims is not conditioned upon the signing of this form.
7. I understand that **AcariaHealth** cannot promise that the person or organization you want to share your health information with will not share it with someone else.
8. AcariaHealth, Inc., its affiliated covered entities, employees and officers are released from any legal responsibility or liability for disclosure of the above information to the extent indicated or authorized herein.

*(Signature of Patient, Parent, or *Legal Representative)*

(Date)

(Print Name)

*If signing on behalf of a patient please describe your authority and provide related documentation.

(Legal Representative Name and contact information)

(Relationship to patient)

If you have questions about the use/disclosures of your health information contact the Privacy Officer at 855-422-2742 Ext. 8092904 or email: Privacy@AcariaHealth.com.

ASSIGNMENT AGREEMENT (ELECTRONIC/MAJOR MEDICAL)

Patient Name _____ Phone # _____

1. PATIENT RIGHTS AND RESPONSIBILITIES: I have received and understand a list of patient rights and responsibilities.

2. RELEASE OF INFORMATION: I hereby authorize my insurer(s) and any other third party payer who provides coverage to disclose to AcariaHealth any information regarding such coverage, including but not limited to: payments made by such insurer(s) or third party payer(s) to me for services rendered to me by AcariaHealth and the scope and extent of coverage available from time to time. I authorize all medical personnel which may include but is not limited to: nursing agencies, physician offices, laboratory facilities, nursing homes, etc. to provide information to AcariaHealth concerning patient medical history as it may relate to my therapy. I consent to the review of my patient records by any Federal State, or Accrediting Body or Agency as required by Regulatory, Licensing, or Accrediting bodies.

3. ASSIGNMENT OF BENEFITS: I hereby authorize AcariaHealth to request on my behalf and to collect directly all public and private insurance coverage benefits due for supplies and services supplied by AcariaHealth. In the event payments for insurance coverage benefits are made directly to any of the undersigned, the payee will endorse to AcariaHealth all checks for such payments. In consideration of AcariaHealth's agreement to forgo collection of my account for a reasonable period of time, I hereby assign AcariaHealth or its legal representative all my rights, including the right to sue on my behalf or name under my insurance policy to recover charges for services rendered by AcariaHealth. This agreement shall not extinguish or diminish my obligation to pay the full fee to AcariaHealth for services rendered, but I shall receive credit for all sums collected pursuant to this agreement. If I enroll in another insurance plan, it is my responsibility to notify AcariaHealth, otherwise I will be responsible for payment.

4. AGREEMENT TO PAY: As AcariaHealth has agreed to supply me with any supplies and services ordered by me or on my behalf, I agree that I am responsible for payment for all such supplies and services provided to me. AcariaHealth has explained that my insurance will cover _____% of all the allowable amount and that I will be responsible for _____% plus any applicable yearly deductibles not met /co-payments which may amount to \$ _____ total/per prescription. I am ultimately responsible for all charges not covered by his/her insurance.

5. EQUIPMENT RENTAL: I acknowledge that I am responsible for equipment such as IV poles, infusion pumps, or rental devices that are property of AcariaHealth. I warrant the safety and safe keeping of said property, including but not limited to loss, theft, fire, or other damages whatsoever. If the equipment is lost, stolen, or otherwise damaged while in my possession, I shall be liable for payment for the full purchase price of said equipment.

6. CONTAINER CONSENT: I hereby authorize AcariaHealth to dispense non-child resistant containers.
 YES NO

Patient Signature _____ Date _____

Responsible Party _____ Date _____

Relationship to Patient _____

**PLEASE SIGN AND RETURN TO ACARIAHEALTH
USING THE SELF-ADDRESSED ENVELOPE PROVIDED**

PATIENT COMPLAINTS & GRIEVANCES FORM

AcariaHealth strives to provide quality products and services that are consistent with our philosophy that caring is at the heart of everything we do. As stated in the Bill of Rights and Responsibilities, you have the right to expect quality customer care and pharmacy services. You also have the right to voice your service issues, grievances, or complaints about our services without fear of discrimination or disrespect.

If you have a complaint or concern about our services, we ask that you contact us immediately by completing this form, calling us at **800.511.5144** or by visiting our website at AcariaHealth.com. You may also report concerns about safety or quality of care directly to The Joint Commission (**800.994.6610**), URAC (www.urac.org/complaint/), or ACHC (**855.937.2242** or www.achc.org/complaint-policy-process.html).

Within 5 calendar days, AcariaHealth will acknowledge all complaints / grievances and advise that an investigation is underway. Within 14 calendar days, AcariaHealth will send the investigation results and response or resolution to you in writing.

Mail form to:

AcariaHealth, Inc.
6923 Lee Vista Blvd., Suite 300
Orlando, FL 32822

Thank you in advance for bringing your concern to our attention as it will assist us in our continuing effort to improve the quality of our services.

Patient's Name: _____ DOB: _____

Description of the problem/concern/complaint (include dates, times and names, if possible):

Completed by (signature): _____ Date: _____

Relationship to patient (if applicable): _____

(FOR OFFICE USE ONLY)

Patient ID#: _____ Received By: _____

Date Received: _____ Date Submitted to Quality Department: _____

Date of Initial Patient Notification: _____ Issue Type: _____

Date of Resolution: _____ Resolution Completed By: _____

Language Assistance / Nondiscrimination Notice

Nondiscrimination Notice

AcariaHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AcariaHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AcariaHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call 1-800-511-5144, TTY: 711.

If you believe that AcariaHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Civil Rights Coordinator
6923 Lee Vista Blvd., Suite 300
Orlando, FL 32822
Telephone Number: 1-800-511-5144, TTY: 711
Fax: 1-877-541-1503

You can file a grievance in person or by mail, or by fax. If you need help filing a grievance, AcariaHealth is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, D.C. 20201
Telephone Number: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-511-5144 (TTY: 711).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-511-5144 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-511-5144 (TTY: 711)。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-511-5144 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-511-5144 (TTY: 711)번으로 전화해 주십시오.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-511-5144 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-511-5144 (телетайп: 711).

Arabic

توظم ل تصا . ن بالمجا كذا رفواته تمويل اللغا دة لمساعا ت مادخن فإ ، اللغة ركاذ دثتد تكذ إذا :

:رقم 1-800-511-5144 (رقم هاتف الصم وال بكم: 711).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-511-5144 (TTY: 711).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-511-5144 (ATS : 711).

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-511-5144 (TTY: 711).

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-511-5144 (TTY: 711).

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-511-5144 (TTY: 711).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-511-5144 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-511-5144 (TTY:711) まで、お電話にてご連絡ください。

Farsi

لمش ی ایرناگ پرا ورتص بانیا بز یالتهس ، د پزک می وگ نڈنی سیرا ننا بز به رگا :توجه

فرهم می باشد. با 1-800-511-5144 (TTY: 711) تملن باگ پزید.