# Utah Hematology Oncology
OGDENCLINIC

## ONCOLOGY PRESCRIPTION FORM

**NAME** _____

MRN _____ Date _____

Diagnosis _____

Allergy _____

Insurance _____

_____

**PRESCRIPTION FORWARDED TO**

_____

Date _____

**TRANSFER NOT DOCUMENTED IN PT CHART**

_____

Date _____

**PATIENT CONTACTED**

Initials_____ Date_____

❑ Spoke ❑ LVM ❑ Unable ❑ DR-DNC

*Contact should occur within 1 business day. DR-DNC Dr. request do not contact.*

**PHARMACIST REVIEW**

*Chart/Dose/Intrx Plan of Care*

Initials_____ Date_____

**PRESCRIPTION REQUIREMENTS** *(Check all that apply)*

❑ Prior Auth

❑ Copay Card

❑ Grant obtained from

❑ No Insurance

❑ Free Drug

**PATIENT EDUCATION**: (Check all that apply)

Initials _____ Date _____

❑ Educational material provided and reviewed

❑ Patient expresses understanding of instructions/education

❑ Drug cost-effectiveness/ability to pay/in-network discussed/Approved

❑ Welcome Letter, Patient Rights and Payment Agreement & Payment Policy received by patient.

❑ Side effects/Storage/Missed doses

❑ How to contact the pharmacy (refills/after hrs./emergency/grievance)

❑ Starter Pack from manufacturer provided

**DOCUMENTATION IN CARE PLAN**

Initials _____ Date _____

Scheduled Start Date _____

Refill Queue Date _____

Notes _____

_____

_____

_____

_____

_____

_____

_____

## PHARMACY WELCOME PACKET

### HOW TO CONTACT OGDEN CLINIC SPECIALTY SERVICES, LLC DISPENSING MEDICAL PRACTITIONER CLINIC

- Please call us at (801) 689-3910 Monday through Friday, during the hours of 8:30 AM to 4:30
- PM, for questions regarding your medications.
- A Pharmacy Technician will be available during normal business hours to answer questions you may have regarding your prescription, including questions about order status or claim-related inquiries. We will respond to your questions in 24 hours. After regular clinic hours, our on-call physician is available for urgent needs, emergencies or disasters.
- Please contact us or your treatment team with any side effects that you may be experiencing, and questions regarding storage and missed doses.
- We will contact you directly with medication recalls that pertain to medications you have taken.

### HOW TO OBTAIN A REFILL MEDICATION:

- To request refills from the provider, please contact your treatment team at (801)476-1777.
- If you have refills available on the prescription, please contact us 4-5 days prior to needing your prescription.

### ALL PATIENTS HAVE THE RIGHT OF CHOICE OF WHERE TO FILL THEIR MEDICATIONS.
### HOW TO TRANSFER YOUR PRESCRIPTION TO A DIFFERENT PHARMACY:

- Please have the pharmacy that you wish to transfer your prescription to call your provider's medical assistant at (801)476-1777.

### HOW TO DESTROY HAZARDOUS MEDICATIONS PROPERLY:

- You may take your unused hazardous medications to any city office and drop them in the mediation disposal bin and they will be destroyed, or you may contact the town that you reside in for information on medication "take-back" dates.

### RECEIVING YOUR MEDICATIONS IN A TIMELY MANNER:

- We are currently only able to provide prescription services to patients seen at Utah Hematology
- Oncology clinics.
- Our goal is to have your medications ready for pick-up 4-5 days prior to your next cycle depending on your treatment plan. Please call us directly at (801)689-3910 if you have not heard from the pharmacy or your treatment team regarding your medications.
- We are currently limited to the insurance prescription plans that we can bill. Please contact us and we will help to find you an in-network pharmacy, if needed.
- If we do not stock the medication you need, we will help you obtain that medication through another pharmacy.
- If you need help paying for your medications, please let us know. There are many options to help pay for your medication. Contact us at (801)689-3910

### PATIENT RIGHTS AND RESPONSIBILITIES:

- A copy of our Patient Rights and Responsibilities document is attached.
- A copy of our Patient Rights and Responsibilities can also be found in the office dispensary. This document is also included in our Patient Resource Guide that you received from your provider.

## GRIEVANCES AND COMPLAINTS

You have the right to raise complaints with the dispensary verbally or in writing by contacting any one of the parties below:

- PIC – Dr. Carl Gray, carl.gray@ogdenclinic.com, 801.476.1777
- Compliance Officer – Quincy Robinson, quincy.robinson@ogdenclinic.com, 801.475.3422
- Department of Justice- https://www.justice.gov/actioncenter/submit-complaint
- ACHC – Credentialing Organization (855-937-2242)

## EMERGENCY PROTOCOLS

Alternative methods for emergency situations

- In the event of an emergency making it impossible for patients to acquire medication through Utah Hematology Oncology dispensary, the dispensary's regular lines shall be forwarded to our on-call 'exchange' answering service. Patients calling the regular Ogden Clinic Specialty Services, LLC dispensary number will either be answered directly by dispensary staff or forwarded to an on-call physician who shall transfer the patient and required documentation to the most convenient dispensary to have medications dispensed by that facility. This shall be noted in the patient chart.
- In the event of an emergency preventing patients from personally visiting Ogden Clinic Specialty Services, dispensary staff shall use the electronic medical record software to identify those patients requiring medication refills the soonest. These 'critical' patients shall be contacted first in order to have their medication dispensed at Roe's Health Mart pharmacy until Ogden Clinic Specialty Services dispensary resumes normal functionality.

## PATIENT RIGHTS & RESPONSIBILITIES

### YOU HAVE THE RIGHT TO

- 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.
- Be informed, in advance of care/service being provided and their financial responsibility.
- A copy of our Patient Rights and Responsibilities document can be found at our pharmacy. This document is also included in our Patient Resource Guide that you received from your provider.
- Receive information about the scope of services that the organization will provide and specific limitations on those services.
- Participate in the development and periodic revision of the plan of care.
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable.
- Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality.
- Be able to identify visiting personnel members through proper identification.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property.
- Voice grievances/complaints regarding treatment or care or lack of respect of property, or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal.
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated.
- Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information (PHI).
- Be advised on the agency's policies and procedures regarding the disclosure of clinical records.
- Choose a healthcare provider, including an attending physician, if applicable.
- Receive appropriate care without discrimination in accordance with physician's orders, if applicable.
- Be informed of any financial benefits when referred to an organization.
- Be fully informed of one's responsibilities.

### CUSTOMER RESPONSIBILITIES

You have the responsibility to:

- Adhere to the plan of treatment or service established by your physician.
- Adhere to the company's policies and procedures.
- Submit any forms necessary to participate in the program, to the extent required by law.
- Participate in the development of an effective plan of care/treatment/services.
- Provide, to the best of your knowledge, accurate and complete medical and personal information necessary to plan and provide care/services.
- Provide any necessary forms and documentation needed to participate in patient management programs, to the extent required by law.
- Ask questions about your care, treatment and/or services, or to have clarified any instructions provided by company representatives.
- Communicate any information, concerns and/or questions related to perceived risks in your services, and unexpected changes in your condition.

- Be available at the time deliveries are made and to allow Ogden Clinic Specialty Services LLC representatives to enter your residence at reasonable times to repair or exchange equipment or to provide services.
- Notify the company if you are going to be unavailable.
- Treat company personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
- Provide a safe environment for Ogden Clinic Specialty Services LLC representatives to provide services.
- Care for and safely use medications, supplies and/or equipment, according to instructions provided, for the purpose it was prescribed and only for/on the individual for whom it was prescribed.
- Communicate any concerns about your/caregiver's/family member's ability to follow instructions or use the equipment provided.
- Protect equipment from fire, water, theft, or other damage. You agree not to transfer or allow your equipment to be used by any other person without the prior written consent of the company and further agree not to modify or attempt to make repairs of any kind to the equipment. Modifying equipment or attempting equipment repairs releases the company from any liability related to the equipment and its uses, and from any resulting negative customer outcomes.
- Except where contrary to federal or state law, you are responsible for equipment rental and sale charges which your insurance company or companies do not pay. You are responsible for prompt settlement, in full, of your accounts unless prior arrangements have been approved by the company administration.
- The Ogden Clinic Specialty Services LLC should be notified of any changes in your physical condition, physician's prescription, or insurance coverage. Notify the Ogden Clinic Specialty Services LLC immediately of any address or telephone changes whether temporary or permanent.

## GRIEVANCES AND COMPLAINTS

You have the right to raise complaints with the dispensary verbally or in writing by contacting any one of the parties below:

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- Compliance Officer – Quincy Robinson, quincy.robinson@ogdenclinic.com, 801.475.3422
- Department of Justice- https://www.justice.gov/actioncenter/submit-complaint
- ACHC – Credentialing Organization (855-937-2242)

Note: *This information can be provided to the patients via the organization's website if the patient has access to the website, the organization provides written instructions on where to locate it on the website, and provides paper copies to patients without access to the website, or who request a paper copy.*

# PAYMENT AGREEMENT & PAYMENT POLICY ACKNOWLEDGMENT

Welcome to Ogden Clinic Specialty Services LLC. We appreciate your business and strive to maintain the highest quality of care possible while controlling health care costs. Please be aware of the following prior to your visit:

**Release of Information Consent and Payment Terms**

1. Your signature authorizes payment of benefits to go directly to the Ogden Clinic Specialty Services LLC or its agents for any services furnished. Your signature requests that payment be made and authorizes release of any information necessary to process the claim. In case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers compensation, or other insurance which is responsible to pay for the services for which the Medicare claim is made.
2. Your signature authorizes the Ogden Clinic Specialty Services LLC to release medical information that may be necessary to request claim reimbursement from insurance companies or other payers to whom claims have been submitted and to release credit information to appropriate information gathering agencies.
3. The clinic cannot accept responsibility for collection of insurance, or other claims. The patient or guarantor is responsible for payment on the account in accordance with our policy. We anticipate payments on your account even though you may have an insurance claim pending per our contractual agreement with the plan.
4. In the event the account is sent to collection the patient or guarantor agrees to pay costs of collections, court cost and reasonable attorney's fees. A collection cost of 21% to 50% of the original balance may be assessed to your account should the matter be referred to a collection agency.
5. In the event of suit the patient or guarantor agrees that Weber County is the county of proper venue.
6. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You agree to notify us if any telephone number, address, or e-mail address provided by you ceases to be your number or address.
7. You agree to pay a charge of $20, and any other amounts provided for by statute, for any returned or unpaid check tendered by you.

**If you have insurance:**

1. Ogden Clinic Specialty Services LLC will submit the charges to your insurance company(s) as a courtesy to you if:
    a) You bring a current insurance card with you to each visit.
    b) You pay any required co-payment at the time of service.
2. Your insurance company may require a co-payment from you. Your contract requires this to be paid at the time of service. Your co-payment may not be your only liability. If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you may be responsible for payment of the service.
3. It may become necessary to bill you for additional amounts due by you. If you receive a statement from us, payment is due 15 days from the date of your statement.

**Medicare and Medicaid Patients:**
You are required to present your Medicaid Card at each visit. If you fail to show your card, and services are denied, you will be responsible for payment.

**CONSENT TO TREATMENT**
I, with my signature, authorize Ogden Clinic Specialty Services LLC, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) maintenance, palliative care, counseling, assessment or review of physical or mental status/ function of the body and the sale or dispensing of drugs, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment. I understand that I have the right to refuse any treatment suggested by my provider.

*I have read and understand all of the above information. I agree to pay for all charges incurred including any collection costs and reasonable attorney's fees and other fees as described above.*

**Signature of Patient or Legal Guardian** _____ **Date** _____

**Please Print the Name of the Patient** _____ **Date of Birth** _____