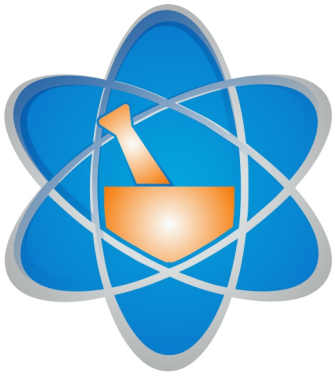

FACTOR ONE SOURCE
PHARMACY

Patient Welcome Packet

Table of Contents

We would like to take this opportunity to welcome you to Factor One Source Pharmacy. We are very happy that you chose us as your pharmacy provider and know that you put your trust in us. We want you to know that we can meet all your pharmacy needs. We are a team of dedicated professionals and are committed to your health and well-being.

Please find the following information in this packet:

- Contact information for Factor One Source Pharmacy and our staff members
- Information about our Patient Management Program
- Patient Rights and Responsibilities
- A Patient Enrollment Form and Medical History
- HIPAA information regarding your confidentiality and privacy
- Consent for Use and Disclosure of Health Information
- A Patient Satisfaction Survey
- A release form for medication dispensed without a child-proof cap

If you have any questions or concerns please feel free to contact us at any time.

We welcome you to Factor One Source Pharmacy.

Please fax all signed forms to 301-876-4395 or return them in the self-addressed envelope provide in this welcome packet.

Contact Information

At Factor One Source Pharmacy, we value being a team of dedicated professionals. We recognize the importance of every person, and promise to give them excellent and personalized care. We are here to counsel, educate, advocate, and empower our patients.

Please don't hesitate to contact us! We can be reached at one of the following numbers:

Pharmacy Phone Number: 844-77-FOSRX (844-773-6779)
Fax Number: 301-876-4395

24-Hour Availability:

For all emergencies, call 844-77-FOSRX and follow prompts.

Dr. Sajal Roy: Cell 570-977-0977

In the event of a disaster or a weather related issue that may affect services, we will make our best attempt to reach you immediately to make sure that you have an adequate supply of medication. If you have problems or concerns you may call us at any time.

Pharmacy Address:
Factor One Source Pharmacy
308 Virginia Avenue
Cumberland, MD 21502

Website:

http://www.fosrx.com

Patient Management Program

The Patient Management Program was developed to assist you in the many facets of your life. It was designed to help you gain access to services that will be a support and improve your health and quality of life. A team of professionals carries it out. We are here to assist and help you. All we ask is that you are willing to follow directions and be compliant with your therapy, if you cannot commit to this then this program may not benefit you. Our Patient Management Program is designed to be an added special touch to your experience with us as your specialty pharmacy. Through our Patient Management Program you will receive special care with:

- Medical/Pharmacy concerns
- Financial Related Questions
- Information and Review of Your Health Insurance Plan, Deductible and Co-Pay Advice and Program Assistance Referrals.
- Any Unmet Physical Needs You Are Experiencing
- Difficulties You May be Having Due to Having a Chronic or Acute Health Care Condition
- Vital Support that can Link You to Outside Resources that can Enhance Your Daily Life.

If you choose to enroll in Factor One Source Pharmacy Patient Management program, please be aware of your rights and responsibilities.

You have the right to:

- To know about philosophy and characteristics of the Patient Management Program
- To have Protected Health Information shared with the Patient Management Program only in accordance with state and federal law
- To identify the staff member of the program and their job title, and to speak with a supervisor of the staff member if requested
- To receive information about the Patient Management Program
- To receive administrative information regarding changes in or termination of the Patient Management Program
- To decline participation, revoke consent or cancel enrollment at any point in time

You have the responsibility to:

- To submit any forms that are necessary to participate in the program, to the extent required by law
- To give accurate clinical and contact information and to notify the Patient Management Program of changes in this information; **and**
- To notify your treating provider/prescriber of your participation in the Patient Management Program, if applicable

If you have any questions please feel free to contact the staff members below who oversee this program.

Dr. Sajal Roy, PharmD, CGP, CACP, CPSO, CSP
Chief Executive Officer
844-77-FOSRX

We encourage you to enroll in Factor One Source Pharmacy Patient Management Program. We know it will benefit you greatly.

Please indicate if you would like to participate by checking your preference.

___ I agree to participate in program. ___ I decline to participate in the program.

Patient's Signature: _____ Date: _____

Factor One Source Pharmacy
308 Virginia Avenue
Cumberland, MD 21502
www.fosrx.com
Phone: 844-77-FOSRX **Fax: 301-876-4395**

Factor One Source Pharmacy has adopted the following statement on consumer rights as the official policy. The consumer/client has the right to:

1. Safe and humane treatment.
2. Be completely informed on these rights.
3. Have **Factor One Source Pharmacy** staff communicate in a language or form that he/she can reasonably be expected to understand.
4. Be informed of responsibilities he/she may have in the care process.
5. Be thoroughly informed of any charges or out of pocket expense not covered by consumer insurance.
6. Be informed of prices; inspect the "Explanation of Bill" or other charges.
7. Have advanced directives.
8. Be provided with information and education relating to aspects of his/her condition that relates to services provided by **Factor One Source Pharmacy** in order to participate in the home therapy plan and plan of care.
9. Be informed of any potential benefits, risks and effects of treatment and will have the opportunity to authorize or refuse treatment.
10. Participate in the development or revision of the plan of care or Patient Management Program.
11. Full access of information and information necessary in order to make decisions regarding services. The consumer's family/guardian may exercise the consumer's rights when the consumer is determined to be unable to make informed decisions.
12. Be treated at all times with respect, courtesy with complete recognition of individuality, and dignity.
13. Service without discrimination against race, color, creed, sex, religion, national origin, sexual orientation, handicap or age.
14. Lodge any complaints with **Factor One Source Pharmacy** and with any other appropriate person, organization or agency such as URAC or The Joint Commission.
15. Be informed and educated on the procedure for lodging complaints in a confidential manner and the procedure for receiving, reviewing and resolving complaints.
16. Express grievance and suggest change in policy, service or staff without worry, intimidation, constraint, or discrimination and not experience unreasonable interruption of services from **Factor One Source Pharmacy**.
17. Expect confidential treatment (HIPAA) of medical and personal records and to decline their release to any individual outside of **Factor One Source Pharmacy** (except in situations where the consumer signs a release of information form). Other exceptions may include third party payment contract.
18. Receive healthcare by the physician of his or her choice.
19. Adequate pain and symptom management.
20. Refuse participation in experimental treatment or research, unless the consumer receives clear documentation and informed consent.

21. Receive services in a timely manner.
22. Be given a prompt and reasonable response to all inquiries.
23. Be assured the staff that provides services is qualified (Credentialed) through education and/or experience.
24. Know identities, title, and affiliations of all staff at **Factor One Source Pharmacy**.
25. Name an advocate of your choice (if requested).
26. Have choice and access to all needed services.
27. Receive a referral for alternative services if consumer is denied service based on their ability to pay.
28. Decline follow-up services.

All of Factor One Source Pharmacy Consumers have the responsibility to:

1. Give up-to-date, complete, and correct health information concerning medical history, medications, allergies and any other information that pertains to the consumer's health.
2. Participate in developing and maintaining a safe environment.
3. Address any financial concerns regarding service or care.
4. Take part in the development and maintenance of their home therapy plan and plan of care (example medication compliance tracking).
5. Request information if there is anything they do not understand.
6. Voice concerns they may have regarding **Factor One Source Pharmacy** services or staff members.
7. Inform **Factor One Source Pharmacy** if they are being hospitalized.
8. Understand and exercise consumer rights to optimize response to and satisfaction with **Factor One Source Pharmacy** services.

Patient Information Form

Patient Information

_____

Patient Name

_____

Patient Address

_____

City, State and Zip Code

_____

Patient Phone

_____

Social Security Number **Date of Birth**

_____

Parent or Guardian Name

Insurance Information

_____

Primary Insurance

_____

Subscriber Name **(Relationship to Patient)**

_____

Policy ID Number **Group ID Number**

_____

Prescription Card ID Number

_____

Secondary Insurance **ID Number**

_____

Emergency Contact Name & Telephone Number

Physician or Clinic Contact Information

_____

Physician Name and or Clinic Name

_____

Address

_____

Physician Telephone Number

_____

Physician's Office Contact Name

_____

City, State and Zip Code

_____

Physician Fax Number

Patient Information Form Page Two

Medical and Medication Information

Medical Information:

Primary Diagnosis:	
Secondary Diagnosis:	
Allergies	

Prescription Medications:

Medication Name	Dose	Frequency

Patient Information Form Page Three

Over-The-Counter (OTC) Medications: *Please check all the medications that you use regularly and/or occasionally*

_____ Pain Reliever

_____Aspirin

____Acetaminophen (ex. Tylenol)

____Naproxen (ex. Aleve)

____Ibuprofen (ex. Advil)

____Decongestant (ex. Sudafed)

____Antihistamine (ex. Chlor-Trimetron)

____Cough Suppressant (ex. Robitussin)

____Combination Products (ex. Cough & Cold, Triaminic)

____ Sleep Aides (ex. Excedrin PM, Tylenol PM, Unisom)

____Anti-Diarrheal (ex. Imodium, Pepto Bismol)

____Laxatives, Stool Softeners (ex. Ducolax, Ex-Lax)

____Diet Aides/Weight Loss Products (ex. Dexatrim, Slim Fast)

____Antacids (ex. Maalox, Mylanta, Rolaids)

____Acid Blockers (ex. Tagamet HB, Pepcid AC, Zantac)

____Other (Please List): _____

Nutritional/Natural Supplements: *Please identify and list all supplements you use regularly and/or occasionally*

Vitamins (ex. Multiple or single such as B Complex, E, C, Beta Carotene etc.)

Minerals (ex. Calcium, Magnesium, Chromium, Collodial Minerals etc.)

Nutrition/Protein Supplements (ex. Shark Cartilage, Fish Oils, Protein Powders, Amino Acids etc.)

Enzymes (ex. Digestive Formulas, Papaya, Bromelain, Coenzyme Q 10 etc.)

Herbs (ex. Ginseng, Gingo Biloba, Echinacea, Herbal Teas, Tinctures, Remedies etc.)

Other

Patient Information Form Page Four

Allergies: *Please check all that apply*

____Penicillin	____Dye	____Insect Venom
____Codeine	____Nitrate	____Dust
____Sulfa Drugs	____Pet Dander	____Mold
____Morphine	____Seasonal Pollen	____Peanut

____Other: _____

____Food Allergy: _____

Please describe the allergic reaction you experienced and when it occurred: _____

Additional Assistance: *Please check all that apply*

____Language: Do you need the assistance of an interpreter? Language Spoken? _____

____Medical Information: Do you need assistance in understanding your health care information sheets or documents?

____Health Insurance/Health Care Benefits: Do you need assistance in understanding your health care insurance and/or health care benefits?

Patient Information Form Page Five

Medical Conditions: *Please check all that apply*

____Heart Disease

____High Cholesterol

____High Blood Pressure

____Cancer

____Ulcers

____Thyroid Disease

____Hormone Related Issues

____Lung Conditions

____Diabetes

____Arthritis or Joint Problems

____Depression

____Epilepsy

____Headaches/Migraines

____Eye Disease

Other (Please list any condition(s) not listed above): _____

Supplies Needed:

Bleeding Disorder Information Sheet

Bleeding Disorder Information

_____

Type of Bleeding Disorder

_____

Severity/Factor Level **Current Product**

_____

Treatment Regimen (Prophylaxis/On-Demand)

_____

Inhibitor Present? **Titer (BU)s**

Treatment Details

_____

Person who infuses the patient

_____

Type of Venous Access (Port/Peripheral etc.)

_____

# of ER Visits **Reason**

_____

# of Hospitalizations **Reason**

Needs Assessment

Does patient have any special needs such as Medic Alert ID, Info for Factor Assistance Programs, Patient Education etc.?

Is the patient disabled, receiving Medicare or intends to apply for Medicare?

Additional Information

_____

Contact Person for Deliveries

_____

Phone

Special Instructions and Date Product Needed

_____

Are parents in the same household?

_____

Signature **Date**

_____

Is inventory needed at another location?

_____

Clinical Review Signature **Date**

For monthly refills please contact us or we will be happy to contact you. If you need product earlier than scheduled, please contact us no later than 2pm. Please note that in an emergency situation, we will get your product to you within 24 hours or less.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

HIPAA

Health Insurance Portability and Accountability Act

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Factor One Source Pharmacy

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 24, 2007, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only

health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

MARYLAND- Factor One Source Pharmacy will not disclose any HIV-related information, except in situations where the subject of the information has provided us with a written consent allowing the release or where we are authorized or required by state or federal law to make the disclosure.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose t health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with information (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Sajal Roy, PharmD, CGP, CACP, CPSO, CSP

Telephone: 844-77-FOSRX Fax: 301-876-4395

E-mail: sroy@fosrx.com

Address: 308 Virginia Avenue, Cumberland, MD 21502

To file a complaint with the U.S Department of Heath and Human Services

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

(800) 368-1019

http://www.hhs.gov/ocr/hipaahowto.pdf

URAC

Phone: (202) 216-9010

Fax: (202 216-9006

Corporate Office

1220 L Street, NW, Suite 400

Washington, D.C. 20005

The Joint Commission

Phone: (630) 792-5800

Fax: (630) 792-5005

The Joint Commission

One Renaissance Blvd

Oakbrook Terrace, IL 60181

PATIENT SATISFACTION SURVEY

We are interested in knowing how satisfied you are with the services and care provided by our pharmacy. Please take a few moments of your time to complete this survey and return in the enclosed self-addressed stamped envelope, email or via fax. Your responses are important to us and will help us serve you better.

How satisfied are you with the following? Please circle your responses.

The ease of contacting staff members with Factor One Source Pharmacy:

Very Dissatisfied Dissatisfied Satisfied Very Satisfied

Staff members contact you on a regular basis:

Very Dissatisfied Dissatisfied Satisfied Very Satisfied

You are informed of all the services provided:

Very Dissatisfied Dissatisfied Satisfied Very Satisfied

Your medication is received in a safe and timely manner:

Very Dissatisfied Dissatisfied Satisfied Very Satisfied

Your needs and concerns are addressed:

Very Dissatisfied Dissatisfied Satisfied Very Satisfied

You are cared for and supported by staff members: Yes No

How do you feel about the safety and quality of care delivered by Factor One Source Pharmacy?

Very Dissatisfied Dissatisfied Satisfied Very Satisfied

Payer Type: Medicaid_____ Medicare_____ Commercial_____

Please share any other additional comments or suggestions that you may have.

_____

_____

Thank you for your time and consideration.

Please do not send this portion back to pharmacy. Please use provided envelope to send to third party company.

Dispensing Medication without a Child-Proof Cap

This form is to verify that you have chosen to relinquish the use of the childproof cap used on your prescription medication.

I, _____ **(**Print Name) would like my medication dispensed without a childproof cap. I understand that Factor One Source Pharmacy is not responsible or liable for any actions that occur as a result of my consent.

_____ _____

Patient's Signature Date

If you have any questions regarding this document, please do not hesitate to contact us.

Please fax this form to 301-876-4395 or return it in the self-addressed stamped envelope provided with this welcome packet.