axis Pharmacy Northwest
axispharmacynw.com

6007 244th Street SW, Suite A2
Mountlake Terrace, WA 98043
Phone: 425.356.3276 Fax: 425.356.3101
Email: LTC@axispharmacynw.com

Record of Admission

Facility Information

Facility Name	Owner/Contact Name	
Address		
Phone Number	Fax Number	Email Address

Patient Information

Medicare # _____

Patient Name	DOB	SEX (circle) M F	SS#
Address			
Phone Number	Medical Conditions		
Allergies to medications and chronic conditions: ☐ No Known Drug Allergies			

Responsible Party/Payee Information

Name: _____

Billing Address: _____

_____

Home Phone: _____ Cell Phone: _____

Relationship to Patient: _____

Please check all that apply:

☐ Medical Decisionmaker ☐ Financial Payee ☐ Both

☐ Patient is Self-POA/Payee

Insurance Information
(please include copies of front and back)

BIN #

Group #

PCN #

ID#

Primary Care Physician Info

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Packaging Style
(Circle all that apply)

Single Monthly Strip DisPill Weekly Bottles

NON-SAFETY CAP Signature _____

Previous Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone Number: _____

Additional Patient Information

How many days' supply does the patient have of current medications? _____

When is the patient's first cycle of medications needed from AXIS Pharmacy? _____

When does patient plan to move into facility? _____

Please also provide fax/copy of patient's current medication list

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POA Agreement Form

Patient Name_____ Facility (home)_____

Patient Address_____

_____

AXIS Pharmacy Northwest agrees to provide medications and other pharmacy items ordered by the patient's physician in accordance with the following terms:

1. The patient and/or responsible party unconditionally guarantees to pay AXIS Pharmacy Northwest for all charges incurred as a result of the medications and/or pharmacy items ordered by the patient's physician, care giver, family, or in person.
2. The responsible party will notify AXIS Pharmacy Northwest of any changes in insurance coverage or pay status immediately and provide the new carrier's coverage information. If the third party does not pay for any reason, the responsible party will be liable for payment of services rendered.
3. Payment for services rendered is due within 30 days of delivery or pickup of medication. Responsible party also agrees to pay any legal fees and court costs incurred in the collection of this account.
4. AXIS Pharmacy Northwest reserves the right to discontinue service to the patient with an account that is past due.
5. AXIS Pharmacy Northwest has my permission to bill the appropriate payer identified (above) for medications and other pharmacy items or services furnished in my care.

THE UNDERSIGNED CERTIFIES THAT HE/SHE/THEY HAVE READ THE ABOVE AGREEMENT AND HEREBY ACCEPT ALL TERMS AND CONDITIONS CONTAINED HEREIN.

POA Name (print)_____

POA Name (sign)_____

Address_____

Phone_____ Cell _____

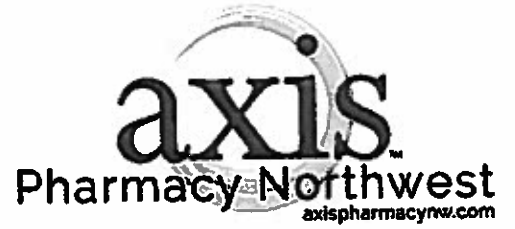
Fax_____ Email_____

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the AXIS Pharmacy Northwest Patient Notice of Privacy Practices effective January 1, 2017.

Patient or Guardian
Signature:_____

Date: _____



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 describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health

information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health

information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

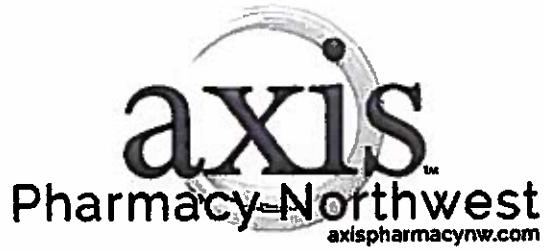
Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will**

not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with Dr Hugh Sauer, Compliance Officer.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us (425-356-3276) if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.



Patient Request for non-safety caps on prescription containers

Federal regulations require that most oral medications be packaged and dispensed with child-resistant caps or "safety caps." The purpose of the legislation is to prevent children's accidental ingestion of medications.

If you prefer that our pharmacists DO NOT use this type of packaging for your medications (alternative packaging is often required in the adult family home environment) you (or your representative) must sign the waiver below. Please keep a copy of the signed form for your records and send it to AXIS Pharmacy NW by

- **FAX at 425-356-3101**
- **Mail at AXIS Pharmacy NW, 24255 Van Ry Blvd, #A1, Mountlake Terrace, WA 98043**
- **Email at LTC@axispharmacynw.com**

Authorization

By signing below, I request and acknowledge that ALL of my prescriptions dispensed by AXIS Pharmacy NW on and after the date of signature will be packaged in NON-safety containers.

_____

Patient Name (please print)

_____ _____

Patient or patient representative signature **date**

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Formally Shiraz Specialty Pharmacy

Welcome to Axis Pharmacy Northwest!

It is with great pleasure that we welcome you to Axis Pharmacy Northwest. We are committed to providing quality services and medications.
We understand that this can be a stressful time for you and your family. If you have any questions or need assistance, we can be reached at ~~(425) 356-3276~~ Monday through Friday 9:00am to 7:00pm and Saturday 10:00am through 2:00pm. 425-672-5800
If after hours questions you may leave a message. We will return your call on the next business day.
Thank you for choosing Axis Pharmacy Northwest. We strive to always meet your needs. Never hesitate to contact us with your questions, concerns, or suggestions.

With warmest regards,

The staff at Axis Pharmacy Northwest

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Website www.axispharmacynw.com
425-672-5800

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Axis Pharmacy Northwest
Patient Rights and Responsibilities

The Patient and Caregiver/POA has the Right

- To considerate and respectful service
- To obtain service without regard to race, creed, national origin, sex, age disability, diagnosis, or religious affiliation
- To confidentiality of all information pertaining to his/her durable medical equipment (DME) subject to applicable law
- To make informed decisions about care
- To reasonable continuity of care and service
- To courteously voice grievances without fear of termination of service or other reprisal in the service process.

The Patient and Caregiver/POA has the Responsibility

- To provide accurate and complete information regarding past and present medical history
- To respect the rights of pharmacy personnel and treat them courteously
- For lost or stolen equipment, or equipment damaged while in their possession
- To notify Axis Pharmacy of any address or telephone number changes
- To meet their financial responsibilities to the pharmacy

Effective 4/30/2020

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Mission and Vision Statement for Axis Pharmacy Northwest

Axis Pharmacy Northwest will always offer trustworthy, timely, cutting edge solutions delivered by friendly, helpful, and knowledgeable people. Our professionals will remain adaptable to changing market conditions while providing and supporting an interactive network that encourages collaboration among healthcare professionals and our valued patients