SoHum Health
Community Clinic

SHCC 340B & Patient Financial Agreement

The following is an agreement to provide Cloney's pharmacy with credit/debit card information upon pick-up of those medications at SHCC:

I, _____ (Print Name) have requested that my medications be delivered to SHCC. Before I pick-up the medication, I agree to pay Cloney's with a credit/debit card. This agreement applies to any refills of the medication which are delivered to SHCC. If at any time I no longer want delivery of medications, I will give SHCC at least a week advanced notice.

_____ _____

Patient Signature Date

CLONEY'S RED CROSS PHARMACY

525 5th Street, CA 95501
Phone: (707) 443-1614 ~ Fax: (707) 443-4461
www.cloneys.com

PATIENT INFORMATION FORM

For Southern Humboldt Clients

☐ New Patient ☐ Updating My Information

Please fill out completely and print clearly:

Patient's Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐ Male ☐ Female

Primary Phone #: _____ **Secondary Phone #:** _____

Patient Address: _____

City: _____ State: _____ Zip: _____

DRUG ALLERGIES	TYPE OF REACTION

Do you need Easy-Open caps? ☐ Yes ☐ No

Would you like automatic refills? ☐ Yes ☐ Yes, and synchronize my meds to fill every 30 days ☐ No

I am allowing the following person(s) to pick up my prescriptions/access my health information:

_____

_____

_____

Patient Signature: _____ **Date:** _____

Fax this completed form and Prescription Insurance information to Cloney's Red Cross Pharmacy at (707) 443-4461

Cloney's Use Only:
☐ Information entered into QS1 and Prescribe Wellness. Date _____ Initials: _____

1/24/2020
9/6/2018

_____RED CROSS PHARMACY
525 5th Street Eureka, CA 95501
Phone: (707)443-1614 ~ Fax: (707)443-4461
www.cloneys.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Name of person(s) authorized to receive information/pick up prescriptions:
_____

Initial Below:

_____ I understand that the person or entity that receives the information is not a healthcare provider or health plan covered by the federal privacy regulations. The information described above may be re-disclosed and no longer protected by these regulations.

_____ I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by the authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Cloney's Pharmacy, Inc.

_____ I understand that if I agree to sign this authorization form, which I am not required to do, I will be provided a signed copy of the form.

_____ I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization.

_____ I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Cloney's Pharmacy, Inc. I am aware that my withdrawal will not be effective as to use and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization expires: _____ or ☐ indefinitely

Signature of patient or representative: _____ Date: _____

CLONEY'S PRESCRIPTION PHARMACY
2515 Harrison Ave Eureka, CA 95501
Phone: (707)443-7086 ~ Fax: (707)443-0302

CLONEY'S RED CROSS PHARMACY
525 5th St Eureka, CA 95501
Phone: (707)443-1614 ~ Fax: (707)443-4461

CLONEY'S McKINLEYVILLE PHARM
1567 City Center Rd McKinleyville, CA 9551
Phone: (707)840-9923 ~ Fax: (707)840-9928

CLONEY'S LONG TERM CARE
525 5th St Suite B Eureka, CA 95501
Phone: (707)443-8452 ~ Fax: (707)443-3059

Credit Card Auto Pay Authorization Form

Cardholder Information:

Name (please print)

Billing Address (where c.c. bill is received) City State Zip

Phone Email

Account to be charged (please circle): Visa MasterCard Discover American Express

Last 4 digits of Card Number: XXXX-XXXX-XXXX-__ __ __ __

Patient Information:

Name (please print) Birth Date

Address City State Zip

Phone Email

Credit Card Auto Pay Policy (to be signed by Cardholder)

By signing below you are authorizing Cloney's Pharmacy, Inc. to automatically charge your credit card for any orders for the patient indicated on this form prior to delivery.
Credit Card Auto Pay can be cancelled at any time by submitting a 24 hour written notice of intent to cancel. Cloney's Pharmacy, Inc. is not responsible for any charges incurred during this 24 hour period.
Credit Card Auto Pay will be cancelled if your card is declined more than three times. You will not be eligible for Auto Pay for a period of 1 year after the date of cancellation.
Cloney's Pharmacy, Inc. is not responsible for any bank charges, overdraft, or transmission fees incurred by your banking organization.
Any changes to Credit Card Auto Pay information will require completion of a new form.

I have read and agree to abide with the above Credit Card Auto Pay Policy.

Signature Date

Print

Remember to get a copy of patient's pharmacy insurance card

Specific info on card needed:

Rx Bin# --RX Grp # -- RX Pcn# -- RX phone#

Unless partnership…..

Effective Date: *August 23, 2014*

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.

If you have any questions about this notice, please contact the corporate offices of Cloneys Pharmacy Inc. 525 5th St., Eureka, CA 95501, 707.443.1614. Cloneys Pharmacy Inc., dba Cloneys Red Cross Pharmacy, Cloneys Prescription Pharmacy, Cloneys Long Term Care Pharmacy, and Cloneys McKinleyville Pharmacy.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer, at the address above.

For Treatment . We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. Information obtained from your physician may be used to dispense prescription medications to you.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment. We may disclose your PHI to the pharmacy benefits managers retained by your insurer for those same payment purposes.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. We may use your PHI to review and assess the quality of the services we provide. We may disclose your PHI to our attorneys and auditors for assistance with legal compliance and financial reporting requirements. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. The PHI disclosed must pertain to that relationship. We may also disclose PHI for quality assessment and improvement activities, credentialing and training activities, health care fraud and abuse detection, and for compliance issues.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. (or in response to a valid subpoena or other legal process).

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance respect with civil rights laws. We may disclose to the FDA or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information. You will be notified if there is a breach of your unsecured protected information that compromises the security or privacy of your PHI.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to HIPAA Compliance Officer, Cloneys Pharmacy Inc, 525 5th St., Eureka, CA 95501. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy

form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to HIPAA Privacy Official. You must include a reason that supports your request for amendment. In certain cases, we may deny your request. You then have the right to file a statement of disagreement with the decision and we may provide a rebuttal to your statement.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. The accounting will exclude certain disclosures, such as those made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, and disclosures for notification purposes. To request an accounting of disclosures, you must make your request, in writing, to HIPAA Privacy Official at the address listed above. Your request must specify the time period and cannot be longer than two years. The first accounting that you request within a twelve month period will be provided free of charge. You will be charged for the cost of providing addition accountings.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to HIPAA Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. In the event that we do grant your request, however, we will abide by the restriction as it related to your PHI on a going forward basis.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www. Cloneys.com. To obtain a paper copy of this notice, you may contact us in person, or by mail addressed to HIPAA Privacy Officer at 525 5th St., Eureka, CA 95501.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact HIPAA Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint**.