P4 PHARMACY WELCOME AND INFORMATION PACKET

Phone: 385-415-5863

EMAIL: info@p4pharmacy.com

WEBSITE: https://www.p4pharmacy.com

PAYMENT PORTAL: Access the portal link directly from our website!

3583 W 9800 S Suite 101 B South Jordan, Utah 84095

WELCOME TO P4 PHARMACY

The staff of P4 Pharmacy would like to welcome you! We are excited to provide service for you or your loved one. P4 Pharmacy is a locally owned business based in South Jordan, UT.

At P4 Pharmacy we provide services for patients of long-term care communities (i.e. assisted living, skilled nursing, rehabilitation, home health, youth group homes and hospice). Services include, but are not limited to, consultation, immunizations, medications and delivery!

P4 Pharmacy will work with you, your physician and your insurance company to ensure that your needs are met. Thank you for this opportunity!

We will call on any medication with a copay price above $25 for approval for patients in a youth group home setting or anything above $50 for all other long term care settings!

We offer custom set approval options or anything else that the above terms do not accommodate for your needs! Contact us for more information!

PATIENT INFORMATION

Please make sure to fill out all required fields with (*). All other information is optional but is helpful to ensure the best quality of service!

***Name:** _____ ***Date of Birth:** _____

SSN#: _____ ***Allergies:** _____

***Gender:** Select **Room #:** _____

Primary Doctor: _____ **Doctor #:** _____

Move-in Date: _____

***Community Name:** _____

***Responsible Party (send statements to):** _____

***Street Address:** _____

***City:** _____ ***State:** _____ ***Zip:** _____

***Phone:** _____ **email:** _____

(Email will be used only for delivery of monthly invoice)

***Relationship to Patient:** _____

Prescription Insurance #: _____

***Rx ID #:** _____ **Rx BIN #:** _____

Rx PCN #: _____ **Rx Group #:** _____

Please attach a copy of both sides of the Insurance Card

If we are unable to bill insurance then the Responsible Party will be billed cash price for all medications. We will call on anything over $50 for Long Term Care patients and over $25 for Youth Group Homes patients!

PAYMENT AGREEMENT

P4 Pharmacy will bill all appropriate agencies/insurances when possible, but the resident/patient or responsible party is ultimately accountable for any and all non-covered charges and co-payments.

For Youth Group Homes that are on a grant, the grant does not include medication costs for your child. We will need payment arrangements prior to sending any medications.

- Private Pay: P4 Pharmacy will bill the resident/patient or responsible party will be billed directly if no insurance is available.
- Insurance: After insurance has been billed, the resident/patient or responsible party will be billed for all copays or non-covered charges.
- Hospice: P4 Pharmacy will bill the hospice agency for all related charges. The patient or responsible party will be billed for all noncovered charges.

Create an account on our Payment Portal to gain access to monthly invoices, set up auto pay and receive emailed receipts!

Call us at 385-415-5863 for more information!

I, The individual specified below, agree to allow P4 Pharmacy to use the included credit card, bank account information or other method of payment to pay for pharmacy services as defined above. I understand that this information will be stored securely and that suitable measures will be taken by the pharmacy to protect this information.

*Signature: **Date:**

(By signing this electronic signature I give my consent of following information above)

METHODS OF PAYMENT

Card Payment

If paying by card please access the payment portal through our website at www.P4Pharmacy.com to make a one-time payment or call us about making a payment portal account!

NOTICE OF PRIVACY PRACTICES/HIPAA

Please visit https://www.p4pharmacy.com/HIPAA for our full Privacy Practices.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Therefore, the Pharmacy pledges to protect your health information as required by law. We provide you with this notice of privacy to tell you how we will use and disclose your medical information. **PLEASE REVIEW IT CAREFULLY.**

*Signature: Date:

By signing this document I acknowledge that I have received the P4 Pharmacy Notice of Privacy Practices.

P4 Pharmacy Prescription Medication Agreement

Welcome to P4 Pharmacy, your long-term care pharmacy. As a new resident at _____ we would like to let you know that we will be handling all your pharmacy medications. As a new member to the pharmacy, we would also like to let you know that we strive to keep costs affordable as we can. If you have insurance, please fill out the following section and/or a copy of insurance card.

<u>This information should be printed on your insurance card:</u>

Name of Insurance: _____

Cardholder ID: _____

Bin: _____ PCN: _____ Rx GRP: _____

Utah State Medicaid number if applicable: _____

Optional Medicare A/B ID number (used for vaccinations or flu shots): _____

Note if you have Medicare A/B this insurance only covers hospitals and doctor office visits. A **<u>Medicare Part D plan is required if you want to use insurance to help cover the costs of the medications.</u>

**If you have Utah State Medicaid, please note that not everything will be covered by Medicaid, such as over the counter medications and medications that do meet eligibility requirements. We will do the best we can to keep the over-the-counter medications (OTC) at an affordable price.

**If you are moving into your new residence from a skilled nursing home or rehab, please note that medications will now be your responsibility to cover either by Medicare part D, Commercial plan, Federal plan, Utah State Medicaid, or cash pricing and there maybe copays associated with your medications.

If there are out of pocket expenses or copays, we require to know: Who the responsible party will be to pay the pharmacy invoice, and where the invoice should be mailed or emailed to.

Responsible Party Name: _____

Responsible Party Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Phone Number: _____

Responsible Party Email Address: _____

Invoices will be mailed or emailed at the Beginning of every month, please note that medications that were billed in the month such as July will be invoiced on the August statement, and so on. **If you transfer facilities at the end of the month, you may still receive an invoice the following month.

If you have any concerns or questions regarding your pharmacy copays, invoices, or need assistance please contact the **billing department at 385-415-5863 ext. 2**, open Mon-Fri 9-5pm. Thank you for becoming a part of P4 Pharmacy, your long-term care pharmacy.

Acknowledgement Signature: _____ Date: _____