Welcome Packet

"We Care About Your Health!"

900 Main Street
Paterson, NJ 07503
Phone Number: 862-257-9990
Toll-Free Phone Number: 1-844-WE-R-PLUS (937-7587)
Fax Number: 862-257-9991
Website: **www.pharmacyplusnj.com**
Email: **pplusspecialty@gmail.com**

Dear Patient,

Welcome to **Pharmacy Plus & Surgical Supplies**. We are **excited** about the opportunity to serve you for your pharmacy and medical needs.

Our staff **understand** that your medical condition is **complex** and will require **special knowledge** and **attention**. We also **understand** we need to **collaborate** with your doctors, nurses and insurance provide. We dedicate our work to provide you with **exceptional** personal service that allows you to **achieve** the **most** benefit from your therapy. Our services include, but not limited to:

- Access to a clinical pharmacist 24 hours a day and 7 days a week
- Obtaining financial assistance when available
- Monthly refill reminders
- Insurance benefit verification
- Convenient pick up and delivery services 7 days a week
- Personal Patient Management Program

We are available 24 hours a day at **www.pharmacyplusnj.com** for additional information.

We can also be emailed at **pplusspecialty@gmail.com**

Our Business Hours:

Monday to Friday: 9:00 AM to 9:00 PM

Saturday: 9:00 AM to 6:00 PM

Sunday: 10:00 AM to 3:00 PM

We look forward to providing you the best service possible!

Thank you for choosing **Pharmacy Plus & Surgical Supplies**!

Sincerely,

Dr. Rami Bader and the **Pharmacy Plus & Surgical Supplies** Team

Mission Statement

Pharmacy Plus & Surgical Supplies is a community pharmacy that provides pharmacy services in Northern New Jersey. Through our professionalism, courtesy and respect, **Pharmacy Plus** proudly serves patients and consumers through education, personalized health and well-being consultations.

Professionalism and compassion for both the trade and our patients is a driving force behind **Pharmacy Plus**. Through a collaborative and team approach, staff pharmacists and specialists provide top-tier services for health management. Educating and enabling our patients to live healthier, happier and more comfortable lives is the foundation of **Pharmacy Plus**.

With a firm belief and goal of delivering exceptional healthcare and optimal specialty pharmaceutical solutions, we work closely with patients, prescribers, referral services, insurance providers and industry professionals to ease the administrative burden on both physician and patient. Our highly-trained staff ensures the highest moral, legal and ethical conduct in serving our patients.

Our goal is patient dedication and to provide high-quality pharmaceutical services. Through an innovative, personalized approach and strong community ties with physicians, biopharmaceutical representatives, and other health care providers, **Pharmacy Plus** is perfectly positioned to enhance lives and promote the well-being of its patients.

What is Specialty Pharmacy?

The *Academy of Managed Care Pharmacy* defines "specialty pharmacy" as:

"Specialty pharmacies are distinct from traditional pharmacies in coordinating many aspects of patient care and disease management. They are designed to efficiently deliver medications with special handling, storage, and distribution requirements with standardized processes that permit economies of scale. Specialty pharmacies are also designed to improve clinical and economic outcomes for patients with complex, often chronic and rare conditions, with close contact and management by clinicians. Health care professionals employed by specialty pharmacies provide patient education, help ensure appropriate medication use, promote adherence, and attempt to avoid unnecessary costs. Other support systems coordinate sharing of information among clinicians treating patients and help patients locate resources to provide financial assistance with out-of-pocket expenditures."

Pharmacy Plus provides convenient dispensing and delivery of specialty medications to our patients. Under the supervision of a qualified pharmacist and trained staff, we assist our patients to achieve optimal clinical outcomes while effectively managing the cost of their therapies.

The areas of specialty medicine provided by **Pharmacy Plus** include, but are not limited to:

- Compounding
- Crohn's Disease
- Cystic Fibrosis
- Dermatological Disorders
- Gastrointestinal Disorders
- Hemophilia
- Hepatitis B
- Hepatitis C
- HIV
- Infertility
- Multiple Sclerosis
- Oncology
- Osteoporosis
- Psoriasis
- Rheumatoid Arthritis

Our Story

Pharmacy Plus & Surgical Supplies is a **locally owned** and operated pharmacy since 2012 that offers **health care services** for **all** specialty needs.

Our **commitment** to providing the most **innovative** and **personalized** care is the **standard** at **Pharmacy Plus**.

Our staff have a **relentless** devotion in **optimizing** patient services and clinical excellence

What to expect from Pharmacy Plus & Surgical Supplies:

We recognize that managing a chronic disease or serious illness can feel overwhelming at times. We are here for you. At **Pharmacy Plus**, our staff is **dedicated** to working with you, your doctors and nurses, and family and friends to achieve a fully **integrated** health care team. You are our primary purpose.

You can expect:

➢ Personalized patient care

Our specialty trained staff members will work with you to discuss your treatment plan, and we will address any questions or concerns you may have. We are available for you **24/7**.

➢ Partnership with your Doctor

We will always keep the lines of communication open between you and your doctors and caregivers. We are here to make sure any difficulties you may be having with your treatment are addressed immediately with your physicians.

➢ Regular follow-up

Getting your medications and medical supplies **quickly** and **efficiently** is **vital**. We will be in close contact with you during your treatment, and will be your healthcare **advocate**.

➢ Benefits

Treatment can be costly, and we will help you navigate through the difficulties of the healthcare system to explore every option available to you. Our relations with insurers will help provide you with information and clarifications of your drug and medical benefits. Your **quality** of care is our **highest** mission.

➢ Delivery

We offer **fast** and **convenient** delivery to your home, workplace, or the location you prefer. A **Pharmacy Plus** staff member will contact you prior to your refill due date to coordinate the medications you need, update your medical and insurance records, and to set up and confirm a delivery date and address. All packages require an adult signature unless you have a signature waiver on file with **Pharmacy Plus**.

Please notify **Pharmacy Plus** immediately if your shipment appears to be damaged via telephone at: 862-257-9990 or our Toll-Free Number at: 1-844-WE-R-PLUS (937-7587)

➢ 24/7 Support

Our **Pharmacy Plus** staff is available 24 hours a day, 7 days a week. We are always here to answer any questions or address any concerns you may have.

Financial Obligation and Financial Assistance

Prior to your care beginning, a staff member will notify you of the financial obligations you might incur. These obligations include but are not limited to: out-of-pocket costs such as deductibles, co-pays, co-insurance, annual and lifetime co-insurance limits and changes that occur during your enrollment period.

Insurance claims

Pharmacy Plus & Surgical Supplies will submit claims to your health insurance carrier on the date your prescription is filled. If the claim is rejected, a staff member will alert you so that we can work together to resolve the issue.

Co-pay Assistance Referral Program

Pharmacy Plus & Surgical Supplies has a financial assistance program to help with co-payments to ensure no disruptions in your therapy. These programs include discount coupons from drug manufacturers, co-payment vouchers, and assistance from various disease management foundations and pharmaceutical companies.

Request of Financial Assistance Information

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: ____ /____ /____ Email Address: _____ Male: ☐ Female: ☐
Month Day Year

Cell Phone #: _____ Home Phone #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Medical Information

What is your condition or diagnosis?

_____

What medication or treatment is being prescribed?

_____

Criteria Questions

Number of People in Household (including yourself)? _____

What is the approximate annual gross Household income? _____

Are you a legal U.S. resident? ☐ Yes ☐ No

Do you have Insurance Coverage? ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Primary Insurance Phone#: _____

Primary Insurance ID#: _____ Primary Insurance Group#: _____

Prescription Insurance: _____ Prescription Insurance Phone#: _____

Prescription Insurance ID#: _____ Prescription Insurance Group#: _____

Physician Information

Physician's Name: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Authorization

Signature: _____ Date: _____

Print Name: _____

Patient Rights & Responsibilities

Patient Bill of Rights

You have the right to:

1. **Receive** accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided so you can make informed health care decisions
2. A **choice** of health care providers (pharmacies) that is sufficient to provide you with access to appropriate high-quality health care.
3. **Know** all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions
4. **Considerate**, **respectful** and **nondiscriminatory care** from your doctors, health plan representatives, and other health care providers.
5. **Talk** in **confidence** with health care providers and to have your health care information protected. You also have the right to review and copy your own medication record and request that your record be amended if it is not accurate, relevant, or complete.
6. Have your property and person **treated** with **respect**, **consideration** and **recognition** of patient **dignity** and **individuality**;
7. Be **informed**, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the patient will be responsible;
8. **Receive** information about the scope of services that the organization will provide and specific limitations on those services
9. To **know** about the philosophy, characteristics and eligibility criteria of the patient management program;
10. Be fully **informed** in advance about the care/service to be provided including the health professionals and disciplines that will furnish the care and follow-up, frequency of interventions as well as any modifications to the plan of care;
11. To **identify** the staff member of the program and their job title, and to **speak** with a supervisor of the staff member if requested;
12. **Speak** to a health care professional;
13. **Receive** information about a clinical program offered by the pharmacy, e.g. patient management program;
14. **Participate** in the development and periodic revision of the plan of care;

15. **Refuse** care or treatment after the consequences of refusing care or treatment are fully presented;
16. **Decline** participation, revoke consent or cease to participate from the program at any point in time;
17. Be **informed** of patient rights under state law to formulate an Advance Directive, if applicable;
18. To be able to **identify** visiting staff members through proper identification;
19. Be **free** from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of patient property;
20. **Voice** complaints regarding treatment of care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal;
21. **Confidentiality** and **privacy** of all information contained in the patient record and of Protected Health Information;
22. Be **advised** on **Pharmacy Plus & Surgical Supplies** policies and procedures regarding disclosure of clinical records;
23. To have personal health information shared with other healthcare providers only in accordance with state and federal law;
24. Be **informed** of financial benefits when referred to another organization for service;
25. **Receive** administrative information regarding changes in or termination of clinical programs including but not limited to the patient management program, and;
26. Be fully **informed** of one's responsibilities.

You have the responsibility to:

1. To give **accurate** and **clinical** and **contact** information and to **notify** the pharmacy of any changes;
2. To **submit** any forms or information that is necessary to obtain needed services or participate in a clinical program as required by law;
3. **Take responsibility** for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
4. **Become involved** in your health care decisions.
5. To **notify** their treating provider of their participation in clinical programs offered by the pharmacy including but not limited to the patient management program;
6. **Work collaboratively** with health care providers in developing and carrying out agreed-upon treatment plans.
7. **Disclose** relevant information regarding medications and medical history to our pharmacist
8. **Clearly communicate** your **wants** and **needs** regarding your pharmacotherapeutic regimen and management;
9. **Become** an **active participant** in achieving compliance and adherence to your medication regimen;
10. **Use** the health plan's internal complaint and appeal process to address concerns that may arise should you not receive an adequate and appropriate response from **Pharmacy Plus & Surgical Supplies**.
11. **Avoid** knowingly spreading disease.
12. **Recognize** the reality of **risks** and **limits** of the science of medical care and the human fallibility of the health care professional.
13. **Be aware** of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
14. **Become knowledgeable** about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations and exclusions, rules regarding use of information, and the process to appeal coverage decisions
15. **Show respect** for other patients and health workers
16. Make a **good-faith effort** to meet financial obligations
17. **Abide** by administrative and operational procedures of the health plans and health care providers

NOTICE OF PRIVACY PRACTICES:

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our organization will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Compliance Officer of Pharmacy Plus & Surgical Supplies

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your identifiable health information:

1. **Treatment.** Our organization may use your identifiable health information to treat you. For example, we may perform a follow-up interview and we may use the results to help us

modify your treatment plan. Many of the people who work for our organization may use of disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children, or parents.

2. **Payment.** Our organization may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties who may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

3. **Health Care Operations.** Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our organization may use and disclose your identifiable health information to contact you and remind you of visits/deliveries.

5. **Health-Related Benefits and Services.** Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.

6. **Release of Information to Family/Friends.** Our organization may release your identifiable health information to a friend or family member who is helping you pay for your health care of who assists in taking care of you with your written consent.

7. **Disclosures Required by Law.** Our organization will use and disclose your identifiable health information when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our organization may disclose your identifiable health information to public health authorities who are authorized by law to collect information for the purpose of :

    - Maintaining vital records, such as births and deaths

- Reporting child abuse or neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our organization may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our organization may use and disclose your identifiable health information in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release identifiable health information if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe might have resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legal process
   - To identify/locate a suspect, material witness, fugitive, or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety.** Our organization may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military.** Our organization may disclose your identifiable health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.

7. **National Security.** Our organization may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. **Inmates.** Our organization may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution; and/or (c) to protect your health and safety or the health and safety of other individuals.

9. **Workers' Compensation.** Our organization may release your identifiable health information for workers' compensation and similar programs.

E. RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Compliance Officer of **Pharmacy Plus & Surgical Supplies**. specifying the requested method of contact or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for the treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of disclosure of your identifiable health information, you must make your request in writing to the Compliance Officer, of **Pharmacy Plus & Surgical Supplies**. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records,. You must submit your request in writing to the Compliance Officer of **Pharmacy Plus & Surgical Supplies** in order to inspect and/or obtain a copy of your identifiable health information. Our organization may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to the Compliance Officer of **Pharmacy Plus & Surgical Supplies**. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to requests an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to the Compliance Officer of **Pharmacy Plus & Surgical Supplies.** All requests for an "accounting of disclosures" must state a time period which may not be longer than six years . The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Right to Provide an Authorization for Other Uses and Disclosures. Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note that we are required to retain records of your care.

Consumer/Patient Satisfaction Survey

Thank you for allowing us to provide you Pharmacy services. Please take a few minutes to give us your feedback on your experience. We value your comments and welcome any suggestions you may have to improve our services.

Date Completed:

Questions	Strongly Agree	Moderately Agree	Neutral	Moderately Disagree	Strongly Disagree
I am satisfied with the services received at **Pharmacy Plus & Surgical Supplies**					
Pharmacy Plus & Surgical Supplies met my service expectations					
My medication was dispensed in a timely manner					
My medication order was accurate					
The information received was helpful					
You have been able to reach by phone a person that can answer your questions					
You have received a clear explanation of the amount you have to pay after your insurance pays					
You have received information on how to access **Pharmacy Plus & Surgical Supplies** for refills and other questions					
Pharmacy staff was respectful and polite					
Pharmacy staff provided efficient service					
Pharmacy staff answered my questions					
Questions	**Strongly Agree**	**Moderately Agree**	**Neutral**	**Moderately Disagree**	**Strongly Disagree**
Pharmacy was cleaned and well organized					
Pharmacy staff provided me with health information					
I will bring my medication prescriptions to **Pharmacy Plus & Surgical Supplies** again					
If you have any comments about how **Pharmacy Plus & Surgical Supplies** can improve their service, please write them here.					

Patient Complaint Policy

The patient has the **right** to **freely** voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, product, and billing complaints will be communicated to the Supervising Pharmacist and the Board of Directors.

These complaints will be documented in the pharmacy's complaint file, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing, e-mail, or by telephone within 5 business days after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively. In addition, the pharmacy will assist the patient in contacting the appropriate state agency or third party payer (health plan) if needed.

You may file a complaint with us by completing our **Patient Complaint Form** on the next page, or you may contact:

Pharmacy Plus & Surgical Supplies
Khalid Bader, President, Pharm D.
900 Main Street
Paterson, NJ 07503
Phone Number: 862-257-9990
Toll-Free Phone Number: 1-844-WE-R-PLUS (937-7587)
Fax: 862-257-9991
Email: pplusspecialty@gmail.com

If appropriate, you may also file a complaint with:

New Jersey State Board of Pharmacy
Division of Consumer Affairs
P.O. Box 45025
Newark, New Jersey
07101
Phone: 973-504-6200

or

Our Accreditation Agency:
URAC
1220 L Street, NW
Suite 400
Washington, DC 20005
Phone: 202-216-9010
http://webapps.urac.org/complaint/

Complaint Form

Name of Issuing the Complaint:
Relationship to Patient:
Name of Patient:
Patient Address:

Patient Primary Telephone #:
Patient Cellular Telephone #:
Patient E-mail Address:

If person issuing the complaint is different than the Patient, does the Patient authorize discussion of incident with this person: ___YES ___NO ___N/A

_____
_____

Complaint

Date occurred:
Hour occurred:
Specific Person(s) involved:
Describe Complaint (Be specific):

Action Expected:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to **Pharmacy Plus & Surgical Supplies** for any services furnished by the pharmacy, and I assign my right to receive these payments to **Pharmacy Plus & Surgical Supplies**. I authorize **Pharmacy Plus & Surgical Supplies** to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.

I authorize **Pharmacy Plus & Surgical Supplies** to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.
I certify that the insurance information that I have provided is accurate, complete and current.

_____ _____
Patient or Person Legally Responsible Relationship to Patient Date

Patient Responsibility

I acknowledge that I am responsible for all charges for services provided which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. To the extent no coverage exists under my Health Insurance Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse **Pharmacy Plus & Surgical Supplies** for all costs, expenses and attorney's fees that may be incurred by **Pharmacy Plus & Surgical Supplies** to collect those charges.

_____ _____
Patient or Person Legally Responsible Relationship to Patient Date

ACKNOWLEDGEMENT OF WELCOME PACKET INFORMATION

Please confirm that you have received the **Pharmacy Plus & Surgical Supplies Welcome Packet** by signing and returning this form in the enclosed postage paid envelope. Completed forms may be mailed to:

Pharmacy Plus & Surgical Supplies
900 Main Street
Paterson, NJ 07503

I confirm that I have received the **Pharmacy Plus & Surgical Supplies** *Welcome packet, which includes Hours of Operation, Contact Information, Patient Bill of Rights and Responsibilities, Notice of Privacy Practices, Financial Obligation and Assistance Programs, Patient Satisfaction Survey and Complaint Process.*

Name (Please Print) _____

Signature _____

Billing Address _____

City, State, Zip _____

Phone # _____

Date: _____

Thank you for choosing **Pharmacy Plus & Surgical Supplies** *to service all of your pharmacy needs.*