FLORIDA MEDICAL SUPPLY PHARMACY

MEDICATION TRANSFER FORM (2023)

COMPLETE THE FOLLOWING INFO WHEN A PATIENT NEEDS MEDICATIONS TRANSFERRED FROM ANOTHER PHARMACY

FAX (850-913-9352)

Facility:_____ **Patient:** _____

MEDICATION	STR	RX#	DIRECTIONS	# OF REFILLS	PHARMACY	PHARMACY PHONE #	DOCTOR/ PHONE #

Please complete this form on **ALL new residents with prescriptions from other pharmacies and any patient needing medications transferred from another pharmacy.** Pharmacy must have **each column completed** before any medications can be transferred from another pharmacy or from the patient's doctor. **Don't wait till patient is out of medication.** Transfers of refill authorization may take more then 24 hours. Your cooperation is appreciated. If the current MORS are used, we must have Prescriber Names, Phone number, and Pharmacy and Phone number! Thanks!!

DATE:____/____/____ BY:_____

Florida Medical Supply Pharmacy

5314-A Frank Hough Road
Panama City, Fl 32404
(800) 430-1857 FAX (850) 913-9352

RESIDENT INFORMATION AND RESPONSIBLE PARTY AGREEMENT

FACILITY NAME: _____

RESIDENT INFORMATION: ___MALE___FEMALE DATE: ___/___/_2023_

Name of Resident: _____ D.O.B_____/_____/____

Social Security#_____ MEDICAID#_____Medicare#_____

Allergies: No Known Drug Allergies - Aspirin – Cipro- Codeine- Erythromycin- Keflex- Morphine-Motrin -Penicillin-Sulfa- Tetracycline-Valium- Other_____
(circle)

Responsible Party:_____

Address:_____ _____

City:_____ St:_____ZIP:_____ PHONE:_____

I UNDERSTAND, ACCEPT AND AGREE TO BE BOUND BY THE FOLLOWING TERMS AND CONDITIONS:
(State law may very with regard to the obligation of an agent)

1. I understand that the term "AGENT" in this form refers to one acting on behalf of the resident.
2. I agree that the personnel of the Care Facility are authorized to order/purchase medications, pharmaceutical supplies and service on behalf of the above named resident.
3. I agree to pay for all purchases and charges incurred by the above named resident not paid for by third party payers. This may include charges not covered by Medicaid, Medicare, or other insurance companies, where applicable.
4. I will pay the entire amount due on the billing statement by the 15th of every month and understand that a late charge may be added to the total outstanding balance for delinquency of 30 days or more.
5. I agree to pay for all collection procedures, including court costs and attorney's fee, if necessary, in order to collect any and all delinquent balances.

_____ _____

AGENT'S SIGNATURE DATE

This form required before any services rendered! THANK YOU!!!

Fax to 1-850-913-9352

Florida Medical Supply Pharmacy

5314-A Frank Hough Road
Panama City, Florida 32404
1-850-785-1900

PRESCRIPTION PICK-UP/DELIVERY AUTHORIZATION

Please note that _____ is/are authorized to receive and process all my prescription medications and deliver them to me. I understand that this agent(s) MUST sign each delivery receipt from the pharmacy as proof of delivery/acceptance of the special packaged medications.

_____
(Patient's printed name)

_____
(Patient's signature)

_____ _____/_____/_____
(Patient's Social Security Number) (Date Signed)

Florida Medical Supply Pharmacy

NOTICE OF PRIVACY PRACTICES

Record of Acknowledgment / Documentation of Good Faith Effort to Obtain Acknowledgment

Name of [Resident/Patient]: _____ Date: _____

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is April 14, 2003

Contact Information for Questions, Complaints or Requests Regarding Your Health Information

Should you have any questions concerning our privacy practices, obtaining a copy of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your protected health information, obtaining an accounting of our disclosures of your protected health information, requesting inspection or copying of your medical information, requesting that we communicate information about your health matters in a certain way, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

-Gary M. Posey: "HIPAA Compliance Officer"
5314 – A Frank Hough Road, Panama City, FL 32404
1-850-785-1900 phone, 1-850-913-9352 fax
www.fmspharmacy.com

If you wish, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may mail your complaint to U.S. Department of Health and Human Services, 200 Independence Avenue S. W., Washington, DC 20201; or you may call 1-202-619-0257 or 1-877 696-6775; or you may log on to the internet address, http://www.hhs.gov/ocr

Acknowledgment / Good Faith Effort to Obtain Acknowledgment (check one of the following)

[ ] I certify that I received a copy of the above-named entity's Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.

Date: _____ Signature (Resident): _____

Printed Name: _____

[ ] I certify that I am the authorized representative of the above-identified patient, and that I have received the Privacy Notice on behalf of this individual and that the above-named entity provided me with an opportunity to review this document and ask questions to assist me in understanding the patient's privacy rights. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting health information.

Date: _____ Signature of Representative: _____

Printed Name: _____

Relationship to Individual: _____

[ ] I, _____, certify that I made a good faith effort to obtain the acknowledgment of the above-identified [resident/patient] or his/her personal representative that he/she had a received a copy of the Privacy Notice of the above-identified entity, but was unable to obtain such acknowledgment for the following reason{s}:

[ ] (Resident/Patient) or personal representative refused to sign.
[ ] (Resident/Patient) or personal representative was unavailable to sign.
[ ] Other: _____

Date: _____ Signature/Title: _____

A copy of this document must be provided to the person to whom the Privacy Notice was provided and **a copy must be filed in the patient's record.**