Dear Patient,

Welcome to Metro Drugs Pharmacy, we look forward to providing you with the best service possible for your specialty medication needs.

The staff at Metro Drugs understands that your medical condition is complex and requires specialized knowledge. We are dedicated to providing you with the personal service necessary to ensure that you achieve a beneficial outcome from your therapy including:

- Access to clinically-trained Pharmacists or Nurses 24 hours a day, 7 days a week
- Coordination of prior authorization(s) with your insurance company and physician office
- Compliance monitoring
- Free delivery of medication(s) when minimum purchase is met
- Training on appropriate medication usage
- Education on what to expect from your treatment(s)
- Counseling of any medication concerns
- Refill reminders
- Enrollment in the Patient Management Program which manages side effects, increases compliance, and medication adherence to drug therapy thereby increasing overall improvement of your health. The patient can either call the pharmacy directly at the number below or write an opt-out statement to the address.

In addition, you can access our website at www.metrodrugs.pharmacy for further information about the services that we can provide for you.

We appreciate your patronage and thank you for choosing Metro Drugs.

79 Hudson Street suite 302
Hoboken, NJ 07030
(P) 888.258.0106
(F) 888.258.4242
After hours: (T) 888.475.2388
M-F 8:30AM – 7:30PM
SAT 9AM-3PM
SUN CLOSED

Sincerely,

The Metro Drugs Team

Dear Patient,

On behalf of the company, I would like to welcome you to the Metro Drugs family and thank you for choosing us for your medication needs.

We at Metro Drugs understand that your journey through infertility is stressful and the decisions facing you are both personal and emotional, with financial implications as well. We will alleviate some of the stress you are experiencing by maximizing your benefits and offering you every possible savings on your out of pocket expenses.

For more information, please visit our website at **www.metrodrugs.pharmacy.** We designed it with patients in mind, providing accurate and comprehensive information on all aspects of fertility as well as links to additional websites and resources including injection training videos.

The Patient Services department at the pharmacy may be reached at **888-258-0106 option 3** to guide you thru any concerns that you may have during our normal business hours. If you need any assistance after hours, our Patient Helpline may be reached at **888-475-2388**.

We wish you the best in your journey to become parents and appreciate your business.

Please take a minute to fill out our included Patient Satisfaction Survey, to help us improve our services. We strive to provide the best customer service and would love to hear from you.

Thank you,

Joe Tawil

President & C.E.O.
Metro Drugs

79 Hudson St. Suite 302
Hoboken, NJ 07030
T: 888-258-0106
F: 888-258-4242
After hours: (T) 888-475-2388
Mon to Fri 8:30am-7:30pm
Sat 9am-3pm
Sun CLOSED

Patient Satisfaction Survey

Please send completed survey to: Fax: (888) 258-4242
Email: patientservices@metrodrugs.com

1. **How would you rate the professionalism of our staff?**
   a. Very poor
   b. Poor
   c. Fair
   d. Good
   e. Very good

2. **How would you rate the accuracy of the medications and supplies we gave or sent you?**
   a. Very poor
   b. Poor
   c. Fair
   d. Good
   e. Very good

3. **Rate how easy it is to get in touch with us by phone.**
   a. Very poor
   b. Poor
   c. Fair
   d. Good
   e. Very good

4. **Rate how easy it is to get answers to your questions, follow-up, or help with any concerns you have**?
   a. Very poor
   b. Poor
   c. Fair
   d. Good
   e. Very good

5. **How would you rate the timeliness of scheduling and receiving your medications?**
   a. Very poor
   b. Poor
   c. Fair
   d. Good
   e. Very good

6. **How would you rate your overall experience with Metro Drugs Specialty Pharmacy?**
   a. Very poor
   b. Poor
   c. Fair
   d. Good
   e. Very good

Comments:

___

___

___

What to Expect

We recognize that managing a medical condition can feel overwhelming at times. At Metro Drugs, our staff is dedicated to working with you, your doctors, nurses, and family to achieve a fully integrated health care team. Our primary concern is to ensure that you receive the proper care and treatment.

- **Personalized patient care**
  Our trained staff members will work with you to discuss your treatment plan and we will address any questions or concerns you may have.
- **Collaboration with your Doctor**
  We can act as a bridge to keep the lines of communication open between you and your doctors/caregivers. We are here to make sure any difficulties you may be having with your treatment are addressed immediately.
- **Regular follow-up**
  Getting your medications and medical supplies quickly and efficiently is paramount. We will be in close contact with you during your treatment and will be your healthcare advocate.
- **Insurance Benefits**
  Treatment can be costly, and we will help you navigate through the complexities of the healthcare system to explore every option available to you. Our experience with various insurers will help provide the information and explanations of your pharmacy benefits specific to your medications.
- **Delivery**
  We offer fast and convenient delivery to a desired location of your choosing. A staff member will contact you five to seven days prior to your refill due date to coordinate the medications you need (if appropriate), update your medical and insurance records (if needed), and to set up and confirm a delivery date and address.
- **In Store Pickup**
  We offer convenient in store pickup of your medications in the New Jersey or New York location.
- **24/7 Support**
  We have pharmacist and nurses on call available 24 hours a day, 7 days a week. We are always here to answer any questions or address any concerns you may have.
  After hour patient helpline: 888-475-2388

Medication Screening and Coverage

A staff member will inform you of the financial obligations you incur subjected by your insurance or other third-party sources. These obligations include but are not limited to: out-of-pocket costs such as deductibles, co-pays, co-insurance, annual and lifetime insurance limits and changes that occur during your enrollment period. The patient will be informed in writing or by phone of any out of pocket expenses that may be incurred if the medication is not covered by their health plan, or if the pharmacy is not in network with your health plan.

Order Delays

The patient (and prescriber if necessary) will be notified by phone in the event that the patient's medication is delayed for any reason. Patients are also instructed to call the pharmacy directly in the event that their medication has not arrived as scheduled so that the pharmacy can investigate the situation.

Insurance claims

Staff will submit claims to your health insurance carrier on the date your prescription is filled. If the claim is rejected, a staff member will notify you so that we can work together to resolve the issue if applicable.

Payments

We are required to collect all payments prior to shipment of your medication. Payments can be paid by any major credit card, or by check, or money order through the mail.

Co-pay Coupons and Financial Assistance Programs

We have access to financial assistance programs to help with payments. These programs include discount coupons from drug manufacturers, co-payment vouchers, and assistance from various disease management foundations and pharmaceutical companies.

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION TO PHARMACY REPRESENTATIVE

This authorization is for use, pursuant to the HIPAA privacy rules, if you are authorizing the release of medical or health information to a spouse, parent, adult child or caregiver for access on an on-going basis to assist with your care and maintaining your information. You understand these records main contain information created by other persons or entities, including physicians or any other health care professionals, as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services and the treatment of sexually transmitted diseases.

Section 1: Patient Information

First Name, Middle Initial, Last Name: ____

Date of Birth MM/DD/YEAR: ____

Street Address: ____________________City: ______________ State/Zip code: __________

Telephone: ____

Section 2: Person Authorized to Receive Information from Metro Drugs

First Name, Middle Initial, Last Name: ____

Date of Birth MM/DD/YEAR: ____

Street Address: ____________________City: ______________ State/Zip code: __________

Telephone: ____

Email Address: __________________________ Relation to Patient: __________________

Section 3: Information to be Released

Describe or list the information that you are asking us to release to the above named person. Initial here if any and all prescription information related to medical and health services received by Metro Drugs

Patient Initials: ___________

Additional Information: ____

____

Section 4: List the Specific Purpose for Requesting this Information

To assist with the management of care, maintenance of information, and administrative functions on my behalf relating the service and/or products received from Metro Drugs. If any additional reason for this release please list: ____

____

Section 5: Expiration Required

This authorization expires MM/DD/YEAR: ____________________ Patient Initials: ____________

Or if specific event occurs: ____________________________ Patient Initials: ____________

For Maryland residents only: This authorization expires 1 year from the date listed below in Section 7

Section 6: Information Regarding this Authorization

- You have the right to revoke the authorization, in writing, to Metro Drugs Privacy Office at any time. The revocation is only effective after it is received and logged by Metro Drugs. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted use and disclosures of Protected Health Information (PHI). You may obtain a copy of this notice from the Privacy Office. Please keep a copy of the authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed to them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment or eligibility for benefits on signing this authorization.
- This authorization must be signed and dated by the patient or signed and dated by the patient's personal representative to include a description of that person's ability to act on behalf of the patient.

Section 7: Patient Signature and Date

I, ___________________________, by signing below, authorize Metro Drugs to use or disclose my protected health information as described above.

Signature and Date: ____

Section 8: Patient Representative Signature and Date

If this authorization is signed by the patient's personal representative, please explain your authority to act below.

____

____

____

Section 9: Return of Authorization

If applicable to your situation, please fill out and mail this completed form to the following:

Director of Specialty Pharmacy
Metro Drugs
79 Hudson Street
Suite 302
Hoboken, NJ 07030
(T) 888-258-0106
(F) 888-258-4242

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

We recognize that each of our customers comes to us with individualized medication needs. We respect the privacy of each of our customer's personal information and understand the importance of keeping this information confidential and secure. We are committed to maintaining the privacy and security of our customer's personal information.

Metro Drugs is a fully licensed pharmacy that operates under state and federal laws. The records we create and maintain related to patients and medication dispensing history are considered to be medical records. Consistent with privacy laws, personally identifiable information may be provided to patients, doctors or healthcare providers, as well as to patients insurance companies as part of the billing process.

What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) is meant to provide patients with an additional level of privacy and accountability in the healthcare service they receive from their providers. The privacy rule of HIPAA affects the way your doctor(s), pharmacy, and other healthcare team members communicate and use your health information. HIPAA is meant to better protect your right to the privacy of your information.

The information included with this acknowledgement will better detail for you how we are committed to protecting your privacy. Please take a moment to review the Notice, then sign and send back your acknowledgement of receipt of our privacy practices.

The quality care that we provide, respect for your right to privacy, and our top-notch service standards are just a few of the ways you can count on us to deliver for you.

Contacting Our Facility

If you have any questions or concerns regarding our practices or services that you have received from this facility, please contact:

Director of Specialty Pharmacy
Metro Drugs
79 Hudson Street
Suite 302
Hoboken, NJ 07030
888-258-0106
888-258-4242

Acknowledgement of Receipt of Notice of Privacy Practices

Please sign your name and date on this acknowledgement form. Return your signed acknowledgement to the Privacy Officer at the address listed above.

First Name, Middle Initial, Last Name: ____

Date of Birth MM/DD/YEAR: ____

Parent or Guardian Name: ____

Relationship to Patient: ____

Signature and Date: ____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can obtain access to this information. Please review carefully.

SECTION A: Uses and Disclosures of Protected Health Information

1. Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as Protected Health Information"). We are also required to provide you with this Notice regarding our policies and procedures regarding your Protected Health Information and to abide by the terms of this notice, as it may be updated from time to time.

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes. We may obtain information to dispense prescriptions and for the documentation of pertinent information hi your records that may assist us in managing your medication therapy or your overall health. For treatment purposes, such use and disclosure will take place in providing, coordinating, or managing healthcare and its related services by one or more of your providers, such as when your pharmacist consults with your physician or a specialist regarding your medications, treatment or condition.

For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing pharmaceutical care services, Such as when your case is reviewed to ensure that appropriate care .was rendered. For reimbursement purposes, your Protected Health Information may be disclosed to one or several intermediaries employed by your plan sponsor including but not limited to insurers, pharmacy benefits managers, claims administers and computer switching companies.

For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement; provider review and training; underwriting activities; reviews and compliance activities; and planning, development, management .and administration. Your information could be used, for example, to assist in the evaluation of the quality of care bat you were provided.

We store some of your Protected Health Information in electronic computer files. We backup our electronic records and employ other precautions to safeguard the integrity of your Protected Health Information. In spite of these precautions it is possible but unlikely that a computer crash or other technological failure could cause the loss of data. In addition reasonable safeguards are employed to protect your Protected Health Information stored on electronic media.

In addition, we may contact you to provide; refill reminders, health screenings, wellness events, inoculations, vaccinations or information about treatment alternatives or other health related benefits and services that may be of interest to you. In addition we may disclose your health information to your plan sponsor. In addition we may contact you for the purpose of fund raising activities. .

We may list and disclose your Protected Health information without your authorization when the pharmacy needs to contact a physician or physician’s staff and is permitted or required to do so without individual written authorization. We may use and disclose your Protected Health information if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them.

From time to time we may employ the services of business associates who may assist us in one or more tasks and who may use, change or create Protected Health Information. Business associates are required to comply with all the privacy regulations on your behalf.

We may disclose Protected Health Information about you without your authorization to comply with workers compensation laws, as required by law enforcement, legal proceedings, public health requirements, and health oversight activities and as required by law.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us as described in Section B.

2. You may ask us to restrict uses and disclosures of your Protected Health Information to carry out treatment, payment, or healthcare operations, or to restrict .uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request.

3. You have the right to request the following with respect to your Protected. Health Information: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of the disclosures of this information by us (we are not required to account to you for disclosures made for treatment, payment,. operations, disclosures to you, disclosures to your care givers for notifications or as otherwise excluded by law); and (iv) the right to receive a paper copy of this, notice upon request. We may require you to pay for this request to cover our costs of copying, labor and postage.

In addition, you may request, and we must accommodate the request, if reasonable, to receive communications of Protected Health Information by alternative means or at alternative locations. To make this request please contact, in writing: Metro Drugs 79 Hudson St Hoboken NJ 07030

4. We may use your name to reference your prescriptions and pharmaceutical care services. You may be required to sign a signature log form to acknowledge receipt of service, to acknowledge receipt of this notice and the disclosures of Protected Health Information as outlined herein. This information may be disclosed by us to other persons who ask for you or your prescriptions by name. You may restrict or prohibit these uses and disclosures by notifying a pharmacy representative orally or in writing of your restriction or prohibition. We are not required, to honor those requests. We are able to provide treatment services to you even if you object to sign the acknowledgment of the receipt of this Notice or if we decide not to honor a request regarding the information in this document. In the event of an emergency or your incapacity, we will do in our reasonable judgment what is consistent with your known preference, and what we determine to be in your best interest. We will inform you of any such uses or disclosures if uses and disclosures would require your signed authorization under such circumstances and give you an opportunity to object as soon as practicable.

5. We may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you, Protected Health Information that is directly relevant to the person's involvement with your care or payment related to your care. In addition we may use 'or disclose the Protected Health Information to notify, identity, or locate a member of your family, your personal representative another person responsible for care or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you object to this use or disclosure, we will do in our judgment what is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick- up filled prescriptions, or other similar forms of Protected Health Information.

6. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all Protected Health Information we maintain. You may receive a copy of this Notice by contacting us as outlined in Section B or upon the receipt of pharmacy care services.

7. If you believe that your privacy rights have been violated, you may complain to us at the location described in Section B or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Section B: Contacting Us

You may contact us for further information at:
Metro Drugs
79 Hudson Street Suite 302
Hoboken, NJ 07030
(T) 888-258-0106
(F) 888-258-4242

AUTHORIZATION - FOR RELEASE OF INFORMATION TO PERSONAL REPRESENTATIVE

The authorization form must be completed and signed in order for the authorization to be valid as defined by the HIPAA privacy rules (45 CFR Parts 160 and 164).

Section 1: This section contains your information. This means that it is your information that would be released in accordance with your authorization.

Section 2: Provide the information of the person who you are authorizing to receive your protected health information ("PHI").

Please note that this may not always be a company. It may also be a specific person or class of persons. For example, your spouse, a specific family member, pharmacy, etc.

Section 3: This section requires that you list the information that you are authorizing Metro Drugs to release. This section must be specific enough for Metro Drugs to understand the nature of your authorization.

Section 4: The purpose for requesting the information should be provided. For example, "maintenance/management of family health care," etc.

Section 5: The authorization must include an expiration date or event. The expiration date or event must either be a specific date in the future (e.g., 01/01/2020), a specific time period (e.g., one year from the date of signature), or an event directly relevant to the individual or the purpose of the use or disclosure (upon death, 4 months after my death). The authorization cannot contain an indeterminate expiration date such as "when I revoke it," "never," N/A, upon notification or leaving the line blank.

Section 6: This section includes information regarding the authorization that you should read.

Section 7: Must be signed and dated.

Section 8: If you are signing the authorization as the legal representative of the individual listed in Section 1, and are other than the parent of the minor child whose information you are authorizing Metro Drugs to release, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

If you have any questions regarding this form, you can contact:

Metro Drugs Privacy Officer
79 Hudson Street
Suite 302
Hoboken, NJ 07030
(T) 888-258-0106
(F) 888-258-4242

METRO DRUGS SERVICE AGREEMENT

CONSENT TO SERVICES

I understand that I have my choice of pharmacy provider. I agree to the provision of services by Metro Drugs. These services may include dispensing and delivery of prescription medications ordered by my doctor, and coordination of nursing services. I understand that my care is directed and monitored by my doctor, and Metro Drugs is not liable for any act of omission when following the instructions of my doctor who is neither the employee nor the agent of Metro Drugs.

PATIENT'S RIGHTS AND RESPONSIBILITIES

I have read and understand the statement of Patient's Rights and Responsibilities associated with this form.

ASSIGNMENTS OF BENEFITS

- Medicare/Medicaid Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf to Metro Drugs.
- Private Insurance: I authorize Metro Drugs to bill my insurance carrier directly for services provided on my behalf.

I authorize payment for any services provided to me by Metro Drugs to be paid directly to Metro Drugs. I understand that I am financially responsible to Metro Drugs for any copayment or noncovered medications not paid by my insurance company. In the event that I do not pay my balance for any amount due within thirty (30) days from the date of the invoice, unless special arrangements are made, late fees may apply. I understand that at any time, I may contact Metro Drugs at **phone number** to request an estimated amount of my financial responsibility for services provided by Metro Drugs.

RETURNED GOODS POLICY

I understand that it is Metro Drugs goal to provide its clients with the finest quality products and support services. I understand that Metro Drugs dispenses and delivers to patients only those medications, solutions, supplies, and equipment that are prescribed by respective patient's doctor for the individual patient or reflect usual and customary items and quantities for the specific therapy ordered by the doctor. I understand that quantities are generally determined and ordered by the patient or his/her representative. I further understand that Metro Drugs policy does not allow it to return medications and/or medical supply merchandise to its inventory for reissue to another patient because it cannot guarantee the sterility or integrity of these products once they have been dispensed and are out of pharmacy oversight. **It is against pharmacy law to return any drugs once they've been issued from Metro Drugs.**

RELEASE OF INFORMATION

I authorize all healthcare providers, insurers, or other parties with healthcare information about me to release to Metro Drugs any and all of my healthcare records, including prescription records, that are related to or may assist in the treatment of the condition(s) for which Metro Drugs is providing services to me (hereafter referred to as "My Records"). I authorize Metro Drugs to release any and all information for My Records as may be necessary for Metro Drugs to receive payments of benefits on my behalf, to comply with audit requests of accrediting bodies or government agencies. I understand that Metro Drugs may use information from My Records that does not identify me personally for data collection, statistical analysis, and other purposes undertaken in Metro Drugs normal course of business. I hereby release, on my behalf and on behalf of my successors and assigns, Metro Drugs and its officers, directors, employees, and agents from any and all liability arising from the release of My Records and from the use of information released from My Records.

Acknowledgement of Receipt of Pharmacy Services Agreement and Rights and Responsibilities

Please sign your name and date on this acknowledgement form.

By signing below, I certify that I have read and accepted the terms of this Metro Drugs Services Agreement. I certify that I am the patient or that I am duly authorized by the patient as the patient's agent to accept and sign this patient agreement and consent on the patient's behalf.

First Name, Middle Initial, Last Name: ____

Date of Birth MM/DD/YEAR: ____

Parent or Guardian Name: ____

Relationship to Patient: ____

Signature and Date: ____

Initial if you authorize the following:

______INITIAL Metro Drugs has my permission to leave messages on my home or cell voicemail.

______INITIAL Metro Drugs has permission to contact me at my place of employment.

CLIENT/PATIENT BILL OF RIGHTS AND RESPONSIBILITIES (URAC)

Metro Drugs shall honor patient rights and responsibilities and inform the patients of their rights and responsibilities in the care process. Patients will receive a written copy of Patient's Rights and Responsibilities at the time of the initial order shipment. Metro Drugs staff will be trained in reviewing Patient Rights and Responsibilities with the Patient/Caregiver and will ensure understanding of these rights and responsibilities. If the patient/caregiver cannot read the statement of rights and responsibilities, an offer will be made to read it the patient/caregiver or offer a translator to provide this service in a language the patient/caregiver understands.

To ensure the finest care possible, as a Patient receiving our Pharmacy services, you should understand your role, rights and responsibilities involved in your own plan of care.

Client/Patient Rights

- To select those who provide you with Pharmacy services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our Pharmacy, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your Pharmacy services, without fear of discrimination or reprisal
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Pharmacy's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosure of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law
- To receive instructions on handling drug recall
- To confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information; PHI will only be shared with the Patient Management Program in accordance with state and federal law
- To receive information on how to access support from consumer advocates groups to receive pharmacy health and safety information to include consumers rights and responsibilities
- To know about philosophy and characteristics of the *patient management* program
- To have personal *health information* shared with the *patient management* program only in accordance with state and federal law
- To identify the *staff* member of the program and their job title, and to speak with a supervisor of the *staff* member if requested
- To receive information about the *patient management* program
- To receive administrative information regarding changes in or termination of the *patient management* program
- To decline participation, revoke consent or disenroll at any point in time
- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care

- 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 client/patient will be responsible
- Receive information about the scope of services that the organization will provide and specific limitations on those services
- Participate in the development and periodic revision of the plan of care
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality
- Be able to identify visiting personnel members through proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property
- Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
- Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information
- Be advised on agency's policies and procedures regarding the disclosure of clinical records
- Choose a health care provider, including choosing an attending physician, if applicable
- Receive appropriate care without discrimination in accordance with physician orders, if applicable
- Be informed of any financial benefits when referred to an organization
- Be fully informed of one's responsibilities

Client/Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Pharmacy personnel
- To notify your Physician and the Pharmacy with any potential side effects and/or complications
- To Notify Metro Drugs via telephone when medication supply is running low so refill maybe shipped to you promptly
- To submit any forms that are necessary to participate in the program to the extent required by law
- To give accurate clinical and contact information and to notify the *patient management* program of changes in this information
- To notify their treating *provider* of their participation in the *patient management* program, if applicable

If you have questions, concerns or issues that require assistance, please call 1-888-258-0106. Complaints will be forwarded to management and you will receive a response within 5 business days.

How to Contact Appropriate Accreditation Bodies if Needed:

ACHC Complaint Information

Website: http://achc.org/contact/complaint-policy-process

General Phone Number: (855) 937-2242

URAC Complaint Information

Website: https://urac.org/complaint/

Email Address: grievances@urac.org

General Phone Number: (202) 216-9010

New Jersey State Board of Pharmacy

Website: https://www.njconsumeraffairs.gov/phar

General Phone Number: (973) 504-6450

Patient Information

After Hours Services:

The after hour's phone number is 888-475-2388 for emergencies only. You may also leave a message at 888-258-0106 after normal business hours for prescription needs to be followed up on the next business day.

Complaint Procedure:

You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination or unreasonable interruption of services. The telephone number is 888-258-0106 when you call ask to speak with the Director of Metro Drugs Pharmacy.

Metro Drugs has a formal grievance procedure that ensures that your concerns will be reviewed and an investigation started within 48 hours and you will be contacted within 5 business days with an update. Every attempt shall be made to resolve all grievances within 14 days. You will be informed in writing of the resolution of the complaint/ grievance.

Adverse Effects to Medication:

If you are experiencing mild to moderate adverse effects to the medication please contact your Physician or Metro Drugs. In an emergency or life threatening reaction, call 911 immediately.

Drug Substitution Protocols:

From time to time it is necessary to substitute generic drugs for brand name drugs. This could occur due to your insurance company preferring the generic be dispensed or to reduce your copay. If a substitution needs to be made a member of the specialty pharmacy staff will contact you prior to shipping the medication to inform you of the substitution.

Proper Disposal of unused Medications:

For instructions on how to properly dispose of unused medications please contact Metro Drugs for instructions or go to the below FDA websites for information and instructions

http://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm

http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm

Emergency Preparedness Plan

Metro Drugs has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact Metro Drugs regarding any medications you may require when there is a threat of disaster or inclement weather so that you have enough medications to sustain you.

If a disaster occurs, follow instructions from the civil authorities in your area. Metro Drugs will utilize every resource available to continue to service you. However, there may be circumstances where Metro Drugs cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of your local rescue or medical facility. Metro Drugs will work closely with authorities to ensure your safety.

Home Safety Information

Here are some helpful guidelines to help you keep a careful eye on your home and maintain safe habits. The safe way is always the right way to do things. Shortcuts may hurt. Correct unsafe conditions before they cause an accident. Take responsibility. Keep your home safe. Keep emergency phone numbers handy.

Medication

- If children are in the home, store medications and poisons in childproof containers and out of reach.
- All medication should be labeled clearly and left in original containers.
- Do not give or take medication that was prescribed to another person.
- When taking or giving medication, read the label and measure doses carefully. Know the side effects of the medication you are taking.
- Throw away outdated medication by pouring down a sink or flushing down the toilet.

Mobility Items

When using mobility items to get around such as; canes, walkers, wheelchairs or crutches you should use extra care to prevent slips and falls.

- Use extreme care to avoid using walkers, canes or crutches on slippery or wet surfaces.
- Always put the wheelchairs or seated walkers in the lock position when standing up or before sitting down
- Wear shoes when using these items and be try to avoid obstacles in your path and soft and uneven surfaces.

Slips and Falls

Slip and falls are the most common and often the most serious accidents in the home. Here are some things you can do to prevent them in your home.

- Arrange furniture to avoid an obstacle course
- Install handrails on all stairs, showers, bathtubs and toilets.
- Keep stairs clear and well lit.
- Place rubber mats or grids in showers and bath tubs.
- Use bath benches or shower chairs if you have muscle weakness, shortness of breath or dizziness.
- Wipe up all spilled water, oil or grease immediately.
- Pick up and keep surprises out from under foot including electrical cords & rugs.
- Keep drawers and cabinets closed
- Install good lighting to avoid groping in the dark.

Lifting

If it is too big, too heavy or too awkward to move alone -GET HELP. Here are some things you can do to prevent low back pain or injury.

- Stand close to the load with your feet apart for good balance.
- Bend your knees and /1straddle" the load.
- Keep your back as straight as possible while you lift and carry the load.
- Avoid twisting your body when carrying a load.
- Plan ahead - clear your way.

Electrical Accidents
Watch for early warning signs; overheating, a burning smell, sparks. Unplug the appliance and get it checked right away. Here are some things you can do to prevent electrical accidents.

- Keep cords and electrical appliances away from water.
- Do not plug cords under rugs, through doorways or near heaters. Check cords for damage before use.
- Extension cords must have a big enough wire for larger appliances.
- If you have a broken plug outlet or wire, get it fixed right away.
- Use a ground on 3-wire plugs to prevent shock in case of electrical /1 fault."
- Do not overload outlets with too many plugs.
- Use three-prong adapters when necessary.

Gas Leak

- Open windows and doors.
- Shut off appliance involved. You may be able to refer to the front of your telephone book for instructions regarding turning off the gas to your home.
- Don't use matches or turn on electrical switches.
- Don't use telephone - dialing may create electrical sparks.
- Don't light candles.
- Call Gas Company from a neighbor's home.
- If your gas company offers free annual inspections, take advantage of them.

Fire
Pre-plan and practice your fire escape. Look for a plan at least two ways out of your home. If your fire exit is through a window, make sure it opens easily. If you are in an apartment, know where the exit stairs are located. Do not use the elevator in a fire emergency. You may notify the fire department ahead of time if you have a disability or special needs. Here are some steps to prevent fires:

- Install smoke detectors. They are your best early warning. Test frequently and change the battery every year.
- If there is oxygen in use, place a "No Smoking" sign in plain view of all persons entering the home.
- Throw away old newspapers, magazines and boxes.
- Empty wastebaskets and trashcans regularly.
- Do not allow ashtrays or toss matches into wastebaskets unless you know they are out. Wet down first or dump into toilet.
- Have your chimney and fireplace checked frequently. Look for and repair cracks and loose mortar. Keep paper, wood and rugs away from area where sparks could hit them.
- Be careful when using space heaters.
- Follow instructions when using heating pad to avoid serious burns.
- Check your furnace and pipes regularly. If nearby walls or ceilings feel hot, add insulation.
- Keep a fire extinguisher in your home and know how to use it.

If you have a fire or suspect fire

1. Take immediate action per plan -Escape is your top priority.
2. Get help on the way - with no delay. CALL 9-1-1.
3. If your fire escape is cut off, close tl1e door and seal the cracks to hold back smoke. Signal help from the window.

Washing your hands appropriately/Infection Control

- The most important step to prevent the spread of germs and infections is hand washing. Wash your hands often. Be sure to wash your hands each time you:
    - Touch any blood or body fluids
    - Touch bedpans, dressings, or other soiled items
    - Use the bathroom or bedpan

  If you are coughing, sneezing, or blowing your nose, clean your hands often. Before you eat, always clean your hands.

- Here’s how you should clean your hands with soap and water:
  - Wet your hands and wrists with warm water.
  - Use soap. Work up a good lather, and rub hard for 15 seconds or longer.
  - Rinse your hands well.
  - Dry your hands well.
  - Use a clean paper towel to turn off the water. Throw the paper towel away.
- Here’s how you should clean your hands with hand sanitizers (waterless hand cleaners):
  - For gel product use one application.
  - For foam product use a golf-ball size amount.
  - Apply product to the palm of your hand.
  - Rub your hands together. Cover all surfaces of your hands and fingers until they are dry

Emergency and Disaster Preparedness Plan

Metro Drugs has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, snow storms, tornadoes and community evacuations. Our primary goal is to continue to service your prescription care needs. When there is a threat of disaster or inclement of weather in the local area Metro Drugs will contact you prior to any atrocities the city may encounter, however if there will be a threat of disaster or inclement of weather in an area you reside which is outside of the tri–state area it is your responsibility to contact the pharmacy prior to the occurrence (if permissible). This process will ensure you have enough medication to sustain you.

Metro Drugs will utilize every resource available to continue to service you. However, there may be circumstances where Metro Drugs cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of your local rescue or medical facility. Please read the guide below to aide you in the case of an emergency or disaster:

1. The pharmacy will call you 3-5 days before an inclement weather emergencies such as a snowstorm utilizing the weather updates as point of reference
   a. If you are not in the tristate area and are aware you will be experiencing inclement weather you are responsible for calling the pharmacy 3-5 days before the occurrence.
2. The pharmacy will send your medication via courier or UPS next day delivery during any suspected inclement weather emergencies.
3. If the pharmacy cannot get your medication to you before an inclement weather emergency occurrence the pharmacy will transfer your medication to a local specialty pharmacy so you do not go without medication.
4. If a local disaster occurs and the pharmacy cannot reach you or you cannot reach the pharmacy, please listen to your local news and rescue centers for advice on obtaining medication. Visit your local hospital immediately if you will miss a dose.
5. The pharmacy recommends all patients leave a secondary emergency number.

If you have an emergency that is not environmental but personal and you need your medication, please contact the pharmacy at your convenience and we will aide you.

ACKNOWLEDGEMENT OF WELCOME PACKET INFORMATION

Please confirm that you have received Metro Drugs by signing and returning this form. Completed forms may be mailed to or dropped off at:

Metro Drugs

79 Hudson Street Suite 302

Hoboken, NJ 07030

I confirm that I have received Metro Drugs 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 Metro Drugs to service all of your specialty pharmacy needs.