Dear Liberty Health Care Services Employee:

Welcome to the McNeill's Pharmacy Mail Order Prescription Benefit Program. Our company has designed this benefit to provide you with start of the art prescription service along with the opportunity to experience a tremendous cost savings. A brief outline of the cost breakdown is illustrated below.

Pharmacy Co-pays

Type Prescription	30-Day Supply Retail Pharmacy	90-Day Supply Mail Order	90-Day Supply Retail Pharmacy
Generic	$10.00	Zero ($0.00)	$30.00
Preferred Brand	$30.00	$100.00	$90.00 - $300.00
Non-Preferred (Single Source)	The greater of $100.00 or 75% of cost	The greater of $300.00 or 75% of cost	The greater of $300.00 or 75% of cost

This introductory packet includes the following:

- Welcome letter
- Employee/Dependent Information Form
  - ✓ Includes credit card billing information
  - ✓ Must be completed and returned before prescriptions can be dispensed and mailed.
- Original Prescription/Refill Request Form
  - ✓ To be used when medications are ordered from the pharmacy.
- Mail Order Benefit Explanation – gives important information on how to order medication
- Frequently Asked Questions - answers to frequently asked questions
- Notice of Privacy Practices
  - ✓ Details our required HIPAA compliance and procedures for protected health information.
  - ✓ Please sign and date the appropriate areas on the last page and return.

McNeill's Pharmacy is the oldest retail pharmacy in NC. McNeill's Pharmacy has been providing quality pharmacy services to residents of southeastern NC for over 100 years.

We are excited about the opportunity to serve you!

Tom Owens, RPh
Pharmacy Manager

McNeill's Pharmacy Mail Order Pharmacy Benefit Program

McNeill's Pharmacy Mail Order Program offers many unique features, including mail service, exceptional customer service, and innovative clinical features. We look forward to managing your mail service pharmacy needs. Here is how the mail service program benefits you:

- **Quality -** Our mail service pharmacy uses state-of-the-art dispensing systems that help our pharmacists provide quality care for participants needing maintenance medications.
- **Convenience -** With the McNeill's Pharmacy mail order program, you receive fast, convenient delivery of maintenance medications delivered directly to your home.
- **Cost Management -** The McNeill's Pharmacy program manages your care by managing costs. When you fill or refill your prescription by mail, you pay only your copayment. Through our mail order program, you can order a prescription supply determined by your benefit plan.

Questions and Answers

What is the difference between a brand and generic drug? Each new medication is given a brand (trade) name and generic (chemical) name. A brand name, protected by a patent, is the name under which the product is advertised and sold. Once the patent has expired, a generic equivalent may be manufactured by any company complying with the U.S. Food and Drug Administration's stringent regulations for safety and efficacy. Generic medications are known only by their chemical names.

What are "maintenance medications?" Maintenance medications are used to treat chronic conditions such as arthritis, diabetes, high blood pressure and ulcers. They are taken on a long-term basis and are available in economic quantities through the mail service program.

How to Use the Program

For new mail service prescriptions, please follow these simple steps:

1. If you need to start your medication right away, have your physician complete two prescriptions. Please be sure the prescription from your physician is legible, includes the drug's name, strength, and the quantity to dispense, the exact daily dosage, the physician's name, phone number and the physician's DEA number.
2. Fill one prescription immediately at a pharmacy and submit the other to the McNeill's Pharmacy mail service program for a supply determined by your benefit plan. This will help you maximize your benefit and save money.
3. Complete the mail service participant profile. Please include a photocopy of the front and back of your prescription benefit card. If your benefit plan includes dependent coverage, please fill out the dependent section(s), even if you are not ordering medications for them at this time. If more space is needed for dependents, please list them on a separate sheet.
4. Mail the participant profile and original prescription(s) to **McNeill's Pharmacy, P.O. Box 339, Whiteville, NC 28472**. Please include your credit card information on the patient profile so that we can charge you for medications that require a copayment. You can expect delivery of your order within 14 days from the date your order is postmarked. Refill orders will take 14 days to receive.

Please note: *A complete patient street address is required for controlled substance medications and an adult signature is required upon receipt.*

For refill prescriptions:

1. When you receive your first prescription, you will receive a prescription refill slip and an envelope. Please follow the refill instructions to order a refill.
2. Remember to order your refill prescription at least two weeks before your current supply runs out.
3. You may also call McNeill's Pharmacy at 866-908-3009 or fax your refill request form to 910-642-3765 to refill your prescription.
4. You may submit your refill request via email to mcneillspharmacy@earthlink.net. Please be sure to include your full name, mailing address, date of birth, telephone number, and refill prescription numbers and/or medication names.

Please fill out the enclosed employee member information form and mail to:
McNeill's Pharmacy, P.O. Box 339, Whiteville, NC 28472

McNeill's Pharmacy Mail Service Program
Frequently Asked Questions

1. How long does it take to get a prescription through the mail service pharmacy?

On your *first* mail service pharmacy order, please allow 14 days from the date you mail the prescription to receive your medication. On subsequent orders containing new prescriptions, please allow 10-14 days. If you order your refill by mail, allow 10-14 days.

2. How is insulin shipped through the mail service pharmacy?

Insulin shipping is overnight delivery, year round. Insulin is cold-packed from April 15th through October15th. From October 16th through April 14th, insulin is not cold-packed, but is still shipped overnight delivery.

3. Do I need to complete a registration form to place an order?

You must register with your first order *only*. Once you register, you do not need to complete another registration form unless specific information changes (for example, if you need to add a health condition or allergy, change your mailing address, etc.). If you need a form to update or change information already on file, please call us and we can mail or fax you a form.

4. Can you review the steps I need to take to begin using your mail service pharmacy?

- First, you must register with our mail service pharmacy by completing the registration form and providing the information requested. Also complete the HIPAA form and make a photocopy of the front and back of your prescription benefit card to send in with your registration form. All of these items should be sent to McNeill's Pharmacy in the enclosed pre-addressed envelope.
- You must obtain a new prescription from your physician for a 90-day supply of the medication. Mail your prescription, Registration & Prescription Order Form, HIPAA form, and photocopy of the front and back of your prescription benefit card in the envelope pre-addressed to McNeill's Pharmacy. **BE SURE TO INCLUDE YOUR CREDIT CARD INFORMATION.**
- If you will be using this medication for an extended period of time (in which case it is considered a maintenance medication), your physician may indicate that you can receive up to three refills. The prescription would then be refillable for up to a year. Prescriptions for controlled substances are refillable for only six months if authorized.
- For long-term medications that you need to start taking right away, ask your doctor for two prescriptions—one for a small supply to fill at a participating retail pharmacy and one for a longterm supply to fill through the mail. **Note:** All subsequent **new** prescriptions from your doctor must be mailed or faxed.
- Remember that delivery may take up to two weeks from the date your order is mailed.· If a generic substitution is available and allowed by your doctor, the generic drug will be dispensed.

5. Can I transfer a prescription from another pharmacy?

Yes. You will need to provide us the prescription number and name and phone number of the dispensing pharmacy. If valid refills are still available, we will be happy to transfer your prescription as North Carolina pharmacy law allows.

6. Can you explain a letter I received from you?

We mail letters to patients for a variety of reasons: for example, to notify them if they are requesting a refill too soon, that a drug is not covered or if a prescription has expired. If you have any questions regarding a notification or how to resolve an issue, contact our pharmacy at 866-908-3009.

7. Why did I receive a generic drug instead of the brand-name drug my doctor prescribed?

Generic drugs usually are considered “preferred” drugs by your plan. They typically have a lower member copayment and cost your plan less, too. Under your benefit plan, if a generic substitute is available and allowed by your doctor, we will dispense a generic drug.

8. How do I order a refill?

There are four easy ways to order prescription refills. Choose the one most convenient for you:

- Place your order with one of our Customer Care representatives by phone. To place your order, call during our regular Customer Care hours and speak to one of our Customer Care representatives. This is especially convenient if any of your order information has changed (for example, your shipping address, dependent information, etc.). The McNeill’s Pharmacy telephone number is 866-908-3009, and Customer Care hours are Monday-Friday, 8:30 am – 6:00 pm; Saturday, 8:30 am – 1:00 pm. *Please note: If your plan requires a copayment, we can not ship your order unless you provide your credit card information for payment.*
- Place your order by mail. Complete the Prescription Order Form and enclose it in the prepaid envelope provided.
- Fax in your refill request form to 910-642-3765.
- Place your order by email. Our email address is mcneillspharmacy@earthlink.net. Please be sure to include your full name, mailing address, date of birth, telephone number, and refill prescription numbers and/or medication names.

9. Can my doctor call in my prescription to the mail service pharmacy?

Yes. Your doctor will need to provide our pharmacy with your name, date of birth, and telephone number when calling in a prescription. Your physician may also fax most prescriptions (with your name, date of birth, and telephone number included) to 910-642-3765.

10. Do I have to use my credit card when ordering?

Yes, you must use your credit card when ordering prescriptions through McNeill’s Pharmacy Mail Service Program.

McNeill's Pharmacy Mail Order Program
Original Prescription/Refill Request

Employee Member Information

_____

Last Name First Name Middle Initial

_____

Mailing Address Apt. or Suite

_____

City State Zip Code

_____(____)_____

Date of Birth (mo/day/yr) Daytime Phone Number

__(____)_____(____)_____

Evening Phone Number Cell Phone Number

Please check/fill out all that apply

- New prescription attached
  - ✓ To be profiled (kept on file for future filling)
  - ✓ Number of prescriptions sent to be profiled: _____
- To be filled
  - ✓ Number of prescriptions sent to be filled: _____
  - ✓ Patient's Name: _____

• Refill request (please list request by prescription number or medication name)

Prescription Numbers: Medication Names:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

*Refill requests can also be called in to McNeill's Pharmacy at 866-908-3009 or faxed to (910) 642-3765.

*New prescriptions can be mailed (accompanied by this form), called in by your physician to McNeill's Pharmacy at 866-908-3009, or faxed by your physician's office to (910) 642-3765. If called in or faxed by physician, we require name, address, date of birth, and telephone number for patient verification.

*This form must be sent in with all new and refill prescription orders that are mailed.

*Refill requests may be submitted via email to mcneillspharmacy@earthlink.net. Please be sure to include your full name, mailing address, date of birth, telephone number, and refill prescription numbers and/or medication names.

Employee Member Information

_____
Last Name First Name Middle Initial Sex

_____
Mailing Address Apt. or Suite

_____
City State Zip Code

_____/_____/_____(____)_____(____)_____
Birth Date (mo/day/yr) Daytime Phone # Evening Phone #

_(____)_____
Cell Phone # Email Address

Physician Information

_____(____)_____
Last Name First Name Phone Number

To maximize cost savings, we will dispense FDA approved generic medications when allowed by your physician, subject to the terms outlined in your plan design.

Check all that apply:

Health Conditions:
- Asthma
- Arthritis
- Diabetes
- Depression
- Glaucoma
- High Cholesterol
- Hypertension
- Thyroid • High • Low

Drug Allergies:
- None
- Aspirin
- Codeine
- Erythromycin
- Iodine
- Penicillin
- Sulfa

Other conditions or allergies:

_____
_____

I prefer "easy open" caps: • Yes • No

Method of Payment
- VISA
- MasterCard
- Discover Card
- American Express

_____
Credit Card # Expiration Date

_____
Signature

_____
Print Name

Dependent #1 • Spouse • Child

_____
Last Name First Name Middle Initial

_____/_____/_____
Birth Date (mo/day/yr) Sex: • Male • Female

Health Conditions:
- Asthma
- Arthritis
- Diabetes
- Depression
- Glaucoma
- High Cholesterol
- Hypertension
- Thyroid • High • Low

Drug Allergies:
- None
- Aspirin
- Codeine
- Erythromycin
- Iodine
- Penicillin
- Sulfa

List other conditions and drug allergies:

_____

Physician Information:

_____(_____)_____
Last Name First Name Phone #

Dependent #2 • Spouse • Child

_____
Last Name First Name Middle Initial

_____/_____/_____
Birth Date (mo/day/yr) Sex: • Male • Female

Health Conditions:
- Asthma
- Arthritis
- Diabetes
- Depression
- Glaucoma
- High Cholesterol
- Hypertension
- Thyroid • High • Low

Drug Allergies:
- None
- Aspirin
- Codeine
- Erythromycin
- Iodine
- Penicillin
- Sulfa

List other conditions and drug allergies:

_____

Physician Information:

_____(____)_____
Last Name First Name Phone #

Dependent #3 • Spouse • Child

_____
Last Name First Name Middle Initial

_____/_____/_____
Birth Date (mo/day/yr) Sex: • Male • Female

Health Conditions:
- Asthma
- Arthritis
- Diabetes
- Depression
- Glaucoma
- High Cholesterol
- Hypertension
- Thyroid • High • Low

Drug Allergies:
- None
- Aspirin
- Codeine
- Erythromycin
- Iodine
- Penicillin
- Sulfa

List other conditions and drug allergies:

_____

Physician Information:

_____(_____)_____
Last Name First Name Phone #

Dependent #4 • Spouse • Child

_____
Last Name First Name Middle Initial

_____/_____/_____
Birth Date (mo/day/yr) Sex: • Male • Female

Health Conditions:
- Asthma
- Arthritis
- Diabetes
- Depression
- Glaucoma
- High Cholesterol
- Hypertension
- Thyroid • High • Low

Drug Allergies:
- None
- Aspirin
- Codeine
- Erythromycin
- Iodine
- Penicillin
- Sulfa

List other conditions and drug allergies:

_____

Physician Information:

_____(_____)_____
Last Name First Name Phone #

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information. We are required by certain state and federal regulations to implement policies and procedures to safeguard your health information. Copies of our privacy policies and procedures are maintained in our business office. We are required by state and federal regulations to abide by the privacy practices described in this notice, including any future revisions that we may make to the notice as may become necessary or as authorized by law.
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care treatment or services you receive is considered *protected health information* (PHI). Accordingly, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices to explain how, when and why we may use or disclose your PHI and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for PHI that we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will promptly post the revision on our company's website at www. libertyhomecare.com. You also may request and obtain a copy of any new/revised Privacy Notice from the contact person identified on the last page of this notice.

Should you have questions concerning our Privacy Notice, our contact information is listed on the last page of this document.

II. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your protected health information for purposes of treatment, payment, or for health care operations. For other uses and disclosures, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release or give access to your protected health information to an outside party performing services on our behalf (*e.g.*, maintaining our computers), we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

1. Use and Disclosures Related to Treatment

We may disclose your protected health information to those who are involved in providing medical and nursing care services and treatments to you. For example we may release protected health information about you to nurses, nursing assistants, medication aides/technicians, medical and nursing students, therapists, other pharmacists, medical records personnel, other consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as long term care facilities, hospitals, diagnostic laboratories, home health/hospice agencies, family members, etc.

2. Use and Disclosures Related to Payment

We may use or disclose your protected health information to bill and collect payment for items or services we provided to you. For example, we may contact your insurance company, health plan, or another third party to obtain payment for services we provided to you.

3. Use and Disclosures Related to Health Care Operations

We may use or disclose your protected health information for the performance of certain functions in monitoring and improving the quality of care and services that you and others receive. For example, we may use your protected health information to evaluate the effectiveness of the care and services you are receiving. We may also disclose your protected health information for auditing, care planning, quality improvement, and learning purposes.

4. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services

We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you, such as a newly released medication or treatment that has a direct relationship to a treatment or medical condition.

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond the above excepted purposes, we are required to have your written authorization, except as otherwise required or permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. Our contact information for purposes of revoking your authorization is listed on the last page of this document. You may use our *Authorization for Use or Disclosure of Protected Health Information* form and/or our *Revocation of an Authorization* form to submit your request to us. Copies of these forms are available upon request.

Examples of uses or disclosures that would require your written authorization include, but are not limited to, the following:

1. A request to provide your protected health information to an attorney for use in a civil litigation claim.
2. A request to provide certain information to an insurance or pharmaceutical company for the purposes of providing you with information relative to insurance benefits or new medications that may be of interest to you.
3. A request to provide PHI to another individual or facility, where no exception from the written authorization requirement applies.

IV. Uses or Disclosures of Information Based Upon Your Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (*e.g.*, because you were not present or you were incapacitated), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose protected health information relevant to the person's involvement in your care. For example, if you are having an adverse reaction to a medication, and are not able to communicate with us effectively, we may inform a family member involved in your care of your drug regimen and possible side effects. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

We may disclose your protected health information to your family members and friends who are involved in your care or who help pay for your care. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (i.e., whether you are alive or dead). You may object to the release of this information. You may use our *Request to Restrict the Use or Disclosure of Protected Health Information* form to notify us of your objection or your objection may be made orally. Our contact information is listed on the last page of this document. (See also Section VI, paragraph 1.)

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations in some instances either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

1. **When Required by Law:**
   We may disclose your protected health information when required by federal, state or local law.
2. **Abuse, Neglect, or Domestic Violence:**
   As required or permitted by law, we may disclose protected health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.
3. **Communicable Diseases:**
   To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.
4. **Disaster Relief:**
   We may disclose protected health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.
5. **Food and Drug Administration (FDA):**
   We may disclose protected health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.
6. **For Public Health Activities:**
   As required or permitted by law, we may disclose protected health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.
7. **For Health Oversight Activities:**
   We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations, including civil rights laws.
8. **To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:**
   We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your protected health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties.

If you are an organ donor, we may disclose your protected health information to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

9. **For Research Purposes:**
   We may disclose your protected health information for research purposes without your authorization only when a privacy board has approved the research project. We may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will not be permitted to remove protected health information from our control. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign a *Confidentiality and Non-Disclosure Agreement* form before being permitted access to protected health information for research purposes. A sample copy of this agreement may be obtained from our business office.
10. **To Avert a Serious Threat to Health or Safety:**
    We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.
11. **For Judicial or Administrative Proceedings:**
    We may disclose protected health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.
12. **To Law Enforcement:**
    We may disclose protected health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.
13. **Minors:**
    If you are an un-emancipated minor as defined under state law, there may be circumstances in which we disclose protected health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.
14. **Parents:**
    If you are a parent of an un-emancipated minor, and are acting as the minor's personal representative, we may disclose protected health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care or services from us, we may disclose protected health information about your child to you. In some circumstances, we may not disclose protected health information about an un-emancipated minor to you. For example, if your child is legally authorized to obtain services (without separate consent from you), and does not request that you be treated as his or her personal representative, we may not be required to disclose protected health information about your child to you without your child's written authorization.
15. **To Personal Representatives:**
    If you are an adult or emancipated minor, we may disclose protected health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.
16. **For Specific Government Functions:**
    We may disclose protected health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.
17. **For Workers' Compensation:**
    We may disclose protected health information about you for purposes related to workers' compensation, as required and authorized by law.

V. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain about you:

1. **To Request Restrictions on Uses and Disclosures of Your Protected Health Information:**
   You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received.

   Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. Such request should be submitted using our *Request to Restrict the Use and Disclosure of Protected Health Information* form. Our contact information for purposes of making such a request is listed on the last page of this document.

   We are not required to agree to your restriction request. You will be informed if we decline your request. If we accept your request, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

2. **The Right to Inspect and Copy Your Health and Billing Records:**
   You have the right to inspect and copy your protected health information, such as your prescription and billing records. In order to inspect and/or copy your protected health information, you must submit a written request to us. If you request a copy of your prescription or billing information or other records, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in filing your requests. We will provide you with information concerning the cost of copying your protected health information prior to performing such service. Such requests should be submitted on our *Request for Inspection/Copy of Protected Health Information* form. Our contact information for such requests is listed on the last page of this document.

   We will respond within thirty (30) days of receipt of such requests. Should we deny your request to inspect and/or copy your protected health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of the denial, if any. In the event of a review, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. Your denial review request should be submitted on our *Denial of Inspection/Copy of Protected Health Information* form. Copies of these forms are available from the contact person listed on the last page of this document.

3. **The Right to Amend or Correct Your Protected health information:**
   You have the right to request that your protected health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we maintain/retain your protected health information. Your requests must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request, unless an extension is necessary, in which case you will be notified, and receive a response to your request within ninety (90) days. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

   We may deny your request if:

   a. Your request is not submitted in writing;
   b. Your written request does not contain a reason to support your request;
   c. The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
   d. It is not a part of the protected health information kept by us;
   e. It is not part of the information which you would be permitted to inspect and copy; and/or
   f. The information is already accurate and complete.

   If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response (of reasonable length) you may have relative to the information and denial process appended to your protected health information.

Your amendment/correction request should be submitted on our *Request for Amendment/Correction of Protected Health Information* form. Copies of these forms are available from our business office. Our contact information for the purpose of making such a request is listed on the last page of this document.

4. **The Right to Request Confidential Communications:**
   You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any protected health information to you at a health care facility, but instead send communication for you to a residential address or Post Office Box. We will agree to your request as long as it is reasonable for us to do so.

   You may submit your requests on our *Request for Restriction of Confidential Communications* form. Copies of these forms are available from the contact person listed on the last page of this document. Our contact information is listed on the last page of this document.

5. **The Right to Request an Accounting of Disclosures of Protected Health Information:**
   You have the right to request that we provide you with a listing of certain disclosures of your protected health information that we have made over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family or friends for notification purposes, disclosures made for national security purposes or to certain law enforcement officials, incidental disclosures, disclosures made as part of a limited data set (for use in research, public health, etc.), or any disclosures made pursuant to your authorization.

   Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2003). Your request may not include releases for more than six (6) years **prior** to the date of your request and may not include releases **prior** to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. We will respond to your request with sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be so notified. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

   You may submit your requests on our *Request for an Accounting of Disclosures of Protected Health Information* form available from our business office. Our contact information is listed on the last page of this document.

6. **The Right to Receive a Paper Copy of This Notice:**
   You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at anytime or you may obtain a copy of this information from our website (as applicable). Our contact information is listed on the last page of this document.

VI. How to File a Complaint about Our Privacy Practices

If you have reason to believe that we have violated your privacy rights or our privacy policies and procedures, or if you disagree with a decision we made concerning access to your protected health information, you have the right to file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Our contact information:

HIPPA Compliance Officer
P.O. Box 339, Whiteville, N.C. 28472
910-642-3065 (Phone)
910-642-3765 (Fax)

McNeill's 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 1st of 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:

HIPAA Compliance Officer
P.O. Box 339, Whiteville, N.C. 28472
910-642-3065 (Phone)
910-642-3765 (Fax)

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 (202) 619-0257 or 1-877-696-6775 (toll free); 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: _____

Printed Name: _____

[ ] I certify that I am the authorized representative of 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 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.