EMBRACE HEALTHCARE INTAKE FORM

PHONE 1-877-816-0942 FAX 1-877-553-7372

(Return pages 1 - 6 to the pharmacy, pages 7 & 8 stay with the patient)

****Page 1 & 2 must be filled out completely to start services with Embrace****

PATIENT INFORMATION (PLEASE PRINT)

Patient's First Name:	Last	Middle	Sex: ☐ Male ☐ Female	Birth Date: / /

Street Address:

City: **State:** **Zip Code:**

Allergies: (Check all that apply) ☐ No Known Drug Allergies ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Other(Please specify)_____

SS#

Patient Phone:

Diagnoses:_____

_____

Diet:_____

_____

GUARDIAN INFORMATION

Name:

Address:			Phone Number:
City:	State:	Zip Code:	Email:

CAREGIVER INFORMATION

Facility Name:	Facility Type (Check one) ☐ ICF ☐ Group Home ☐ Skilled ☐ SLS ☐ Respite Other (Please specify) _____

Address:

City: **State:** **Zip Code:**

Contact Name:	Phone:	Email:	Relationship to Patient:

PRIMARY INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes **(please send a copy, front and back, of the patients insurance card(s))** ☐ No (skip section)

Cardholders Name: **Insurance Company:**

BIN#	PCN#	ID#	Group#

Patient relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

SECONDARY INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes **(please send a copy, front and back, of the patients insurance card(s))** ☐ No (skip section)

Cardholders Name: **Insurance Company:**

BIN#	PCN#	ID#	Group#

PAYEE INFORMATION

Responsible Party/Caregiver's name who is in charge of patient's finances:

Address:			Phone Number:
City:	State:	Zip code:	Fax Number:

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MEDICATIONS/ MEDICAL SUPPLIES DELIVERY INFORMATION

Address for deliveries:

☐ Home

Address listed under patient information

☐ Office Street Address:_____

_____

City:_____ State:_____ Zip Code:_____

☐ Other Street Address:_____

_____

City:_____ State:_____ Zip Code:_____

Do we have permission to leave the package if someone is not there to sign for it? ☐ **Yes** ☐ **No** If yes, please fill out and return the form on page 6

Patient/Individual May Sign for Any Medication Deliveries: ☐ **Yes** ☐ **No**

Medication Administration Records (MARs): ☐ Needed ☐ Not Needed

MEDICATION SPECIAL PACKAGING & START DATE

Package Type: ☐ **Blister Cards** ☐ **Vials** ☐ **Multidose ($25 monthly service charge)**

Please visit https://www.embraceohio.org/faq.html for examples of each type of packaging

Start date for Medications/Supplies?:_____

DAY PROGRAM OR SCHOOL / WORK

Which one does the patient attend?

☐ None ☐ Day Program ☐ Work

☐ School ☐ Other: _____

Days & times attending :

_____

_____

PHARMACY TO CONTACT FOR TRANSFERS

Name:			
Address:			**Phone Number:**
City:	**State**:	**Zip code:**	**Fax Number:**

ACKNOWLEDGMENTS AND RESPONSIBILITIES

_____ **Initials** I have received a copy of Embrace Healthcare Notice of Privacy Practices. Federal regulations require that we obtain proof that our customers have received the Notice of Privacy Practice.

_____ **Initials** The Embrace Healthcare packaging is NOT child resistant. By initialing, you indicate that you are requesting that all medications shall be dispensed in “non-childproof” packaging.

_____ **Initials** I understand that due to the purchase of patient specific medications in advance of your needs to assure all medications are in place each month, a 90 day written notice must be given to Embrace Healthcare before transferring to the pharmacy of your choice.

RESPONSIBLE PARTY / CAREGIVER INFORMATION

Responsible Party/Caregiver is an individual who assists with healthcare decisions

Responsible Party/Caregiver's name:	**Relationship to patient:**

Phone Number: Work: Cell:

The above information is true to the best of my knowledge. I authorize this patient's insurance benefits be paid directly to Embrace Healthcare. I understand that the payee is financially responsible for any balance. I also authorize Embrace Healthcare or insurance company to release any information required to process my claim.

Responsible Party/Caregiver Signature:_____

EMBRACE HEALTHCARE
PHARMACY AND MEDICAL SUPPLY

Medication Information

Patient Name:_________________________ DOB:__________

(Please fill out OR attach a copy of the patient's MAR/PO)

Prescription #:__________________ Medication Name and Strength:______________________________
Directions:____
Start Date:______________ Administration Times:______________ Diagnosis:________________
Physician's Name:________________________ Phone #:__________________ Fax#:________________
Pharmacy Name:_________________________ Phone #:__________________ Fax#:________________

Prescription# :__________________ Medication Name and Strength:______________________________
Directions:____
Start Date:______________ Administration Times:______________ Diagnosis:________________
Physician's Name:________________________ Phone #:__________________ Fax#:________________
Pharmacy Name:_________________________ Phone #:__________________ Fax#:________________

Prescription #:__________________ Medication Name and Strength:______________________________
Directions:____
Start Date:______________ Administration Times:______________ Diagnosis:________________
Physician's Name:________________________ Phone #:__________________ Fax#:________________
Pharmacy Name:_________________________ Phone #:__________________ Fax#:________________

Prescription #:__________________ Medication Name and Strength:______________________________
Directions:____
Start Date:______________ Administration Times:______________ Diagnosis:________________
Physician's Name:________________________ Phone #:__________________ Fax#:________________
Pharmacy Name:_________________________ Phone #:__________________ Fax#:________________

Prescription #:__________________ Medication Name and Strength:______________________________
Directions:____
Start Date:______________ Administration Times:______________ Diagnosis:________________
Physician's Name:________________________ Phone #:__________________ Fax#:________________
Pharmacy Name:_________________________ Phone #:__________________ Fax#:________________

Prescription #:__________________ Medication Name and Strength:______________________________
Directions:____
Start Date:______________ Administration Times:______________ Diagnosis:________________
Physician's Name:________________________ Phone #:__________________ Fax#:________________
Pharmacy Name:_________________________ Phone #:__________________ Fax#:________________

Embrace Healthcare
Pharmacy and Medical Supply

Medication Information

Patient Name:__________________________ DOB:__________

(Please fill out <u>OR</u> attach a copy of the patient's MAR/PO)

Prescription #:__________________ Medication Name and Strength:______________________________________
Directions:____
Start Date:________________ Administration Times:________________ Diagnosis:______________________
Physician's Name:__________________________ Phone #:___________________ Fax#:______________________
Pharmacy Name:__________________________ Phone #:___________________ Fax#:______________________

Prescription# :__________________ Medication Name and Strength:______________________________________
Directions:____
Start Date:________________ Administration Times:________________ Diagnosis:______________________
Physician's Name:__________________________ Phone #:___________________ Fax#:______________________
Pharmacy Name:__________________________ Phone #:___________________ Fax#:______________________

Prescription #:__________________ Medication Name and Strength:______________________________________
Directions:____
Start Date:________________ Administration Times:________________ Diagnosis:______________________
Physician's Name:__________________________ Phone #:___________________ Fax#:______________________
Pharmacy Name:__________________________ Phone #:___________________ Fax#:______________________

Prescription #:__________________ Medication Name and Strength:______________________________________
Directions:____
Start Date:________________ Administration Times:________________ Diagnosis:______________________
Physician's Name:__________________________ Phone #:___________________ Fax#:______________________
Pharmacy Name:__________________________ Phone #:___________________ Fax#:______________________

Prescription #:__________________ Medication Name and Strength:______________________________________
Directions:____
Start Date:________________ Administration Times:________________ Diagnosis:______________________
Physician's Name:__________________________ Phone #:___________________ Fax#:______________________
Pharmacy Name:__________________________ Phone #:___________________ Fax#:______________________

Prescription #:__________________ Medication Name and Strength:______________________________________
Directions:____
Start Date:________________ Administration Times:________________ Diagnosis:______________________
Physician's Name:__________________________ Phone #:___________________ Fax#:______________________
Pharmacy Name:__________________________ Phone #:___________________ Fax#:______________________

EMBRACE HEALTHCARE
PHARMACY AND MEDICAL SUPPLY

Medical Supply Information

Patient Name:__________________________ DOB:___________

(Please fill out OR attach a copy of the patient's MAR/PO)

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

Supply Name:____
Amount:_____________________ Last Fill Date:____________________
Physician's Name:__________________________ Phone #:____________________ Fax#:_______________________
Pharmacy Name:___________________________ Phone #:____________________ Fax#:_______________________

EMBRACE HEALTHCARE
PHARMACY AND MEDICAL SUPPLY

Optional

Permission to Leave Medications/Supplies
No Signature Required

I _____ give Embrace Healthcare permission to leave
Name
medications/supplies, if no one is home, for _____ at
Patient Name
_____. I understand that I take full responsibility
Address
and Embrace Healthcare will not replace any lost, stolen, damaged, etc. products.

Choose one

☐ Permission to Leave
Location (ex: porch, back door, etc.)_____

_____

☐ Key Lock Box **(Requires entry to home)**
Location (ex: right inside the door, kitchen table, etc.)_____

_____

Patient or Caregiver Signature_____

Patient or Caregiver Name Printed _____

Contact Phone Number _____

Date _____

Embrace Notice of Privacy Practices

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

We at Embrace are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. References to "Embrace" "we," "us," and "our" include Embrace Healthcare, and the members of its affiliated covered entites. An affiliated covered entity is a group of organizations under common ownership or control who designate themselves as a single affiliated covered entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). Embrace, its employees, workforce members and members of the Embrace affiliated covered entity who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy Practices ("Notice"). The members of the Embrace affiliated covered entity will share PHI with each other for the treatment, payment and health care operations of the affiliated covered entity and as permitted by HIPAA and this Notice. For a complete list of the members of Embrace's affiliated covered entities, please contact the Privacy Office.

PHI is information that may identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care products and services to you or payment for such services. This Notice describes how we may use and disclose PHI about you, as well as how you obtain access to such PHI. This Notice also describes your rights with respect to your PHI. We are required by HIPAA to provide this Notice to you. Embrace is required to follow the terms of this Notice or any change to it that is in effect. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. If we do so, the updated Notice will be posted on our website and will be available at our facilities and locations where you receive health care products and services from us. Upon request, we will provide any revised Notice to you.

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose your PHI. We have provided you with examples in certain categories; however, not every permissible use or disclosure will be listed in this Notice. Note that some types of PHI, such as HIV information, genetic information, alcohol and/or substance abuse records, and mental health records may be subject to special confidentiality protections under applicable state or federal law and we will abide by these special protections. If you would like additional information about special state law protections, you may contact the Privacy Office.

I .Uses and Disclosures Of PHI That Do Not Require Your Prior Authorization

Except where prohibited by federal or state laws that require special privacy protections, we may use and disclose your PHI for treatment, payment and health care operations without your prior authorization as follows:

Treatment. We may use and disclose your PHI to provide and coordinate the treatment, medications and services you receive. For example, we may disclose PHI to pharmacists, doctors, nurses, technicians and other personnel involved in your health care. We may also disclose your PHI with other third parties, such as hospitals, other pharmacies and other health care facilities and agencies to facilitate the provision of health care services, medications, equipment and supplies you may need. This helps to coordinate your care and make sure that everyone who is involved in your care has the information that they need about you to meet your health care needs.

Payment. We may use and disclose your PHI in order to obtain payment for the health care products and services that we provide to you and for other payment activities related to the services that we provide. For example, we may contact your insurer, pharmacy benefit manager or other health care payor to determine whether it will pay for health care products and services you need and to determine the amount of your co-payment. We will bill you or a third-party payor for the cost of health care products and services we provide to you. The information on or accompanying the bill may include information that identifies you, as well as information about the services that were provided to you or the medications you are taking. We may also disclose your PHI to other health care providers or HIPAA covered entities who may need it for their payment activities.

Health Care Operations. We may use and disclose your PHI for our health care operations. Health care operations are activities necessary for us to operate our health care businesses. For example, we may use your PHI to monitor the performance of the staff and pharmacists providing treatment to you. We may use your PHI as part of our efforts to continually improve the quality and effectiveness of the health care products and services we provide. We may also analyze PHI to improve the quality and efficiency of health care, for example, to assess and improve outcomes for health care conditions. We may also disclose your PHI to other HIPAA covered entities that have provided services to you so that they can improve the quality and effectiveness of the health care services that they provide. We may use your PHI to create de-identified data, which is stripped of your identifiable data and no longer identifies you.

We may also use and disclose your PHI without your prior authorization for the following purposes:

Business Associates. We may contract with third parties to perform certain services for us, such as billing services, copy services or consulting services. These third party service providers, referred to as Business Associates, may need to access your PHI to perform services for us. They are required by contract and law to protect your PHI and only use and disclose it as necessary to perform their services for us.

To Communicate with Individuals Involved in Your Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend, or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care. Additionally, we may disclose PHI to your "personal representative." If a person has the authority by law to make health care decisions for you, we will generally regard that person as your "personal representative" and treat him or her the same way we would treat you with respect to your PHI.

Food and Drug Administration ("FDA"). We may disclose to persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation. To the extent necessary to comply with law, we may disclose your PHI to worker's compensation or other similar programs established by law.

Public Health. We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including the FDA. In certain circumstances, we may also report work-related illnesses and injuries to employers for workplace safety purposes.

Law Enforcement. We may disclose your PHI for law enforcement purposes as required or permitted by law – for example, in response to a subpoena or court order, in response to a request from law enforcement, and to report limited information in certain circumstances.

As Required by Law. We will disclose your PHI when required to do so by federal, state or local law.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to first tell you about the request or to obtain an order protecting the information requested.

Research. We may use your PHI to conduct research and we may disclose your PHI to researchers as authorized by law. For example, we may use or disclose your PHI as part of a research study when the research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners and Funeral Directors. We may release your PHI to coroners or medical examiners so that they can carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Organ or Tissue Procurement Organizations. Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Notification. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.

Disaster Relief. We may use and disclose your PHI to organizations for purposes of disaster relief efforts.

Fundraising. As permitted by applicable law, we may contact you to provide you with information about our fundraising programs. You have the right to "opt out" of receiving these communications and such fundraising materials will explain how you may request to opt out of future communications if you do not want us to contact you further for fundraising efforts.

Correctional Institution. If you are or become an inmate of a correctional institution, we may disclose to the institution, or its agents, PHI necessary for your health and the health and safety of other individuals.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

National Security, Intelligence Activities, and Protective Services for the President and Others. We may release PHI about you to federal officials for intelligence, counterintelligence, protection of the President, and other national security activities authorized by law.

Victims of Abuse or Neglect. We may disclose PHI about you to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

II. Uses and Disclosures of PHI that Require Your Prior Authorization

Specific Uses or Disclosures Requiring Authorization. We will obtain your written authorization for the use or disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI, except in limited circumstances where applicable law allows such uses or disclosure without your authorization.

Other Uses and Disclosures. We will obtain your written authorization before using or disclosing your PHI for purposes other than those described in this Notice or otherwise permitted by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights:

Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy at the site where you obtain health care services from us or by contacting the Privacy Office.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Office. We are not required to agree to the restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or a person on your behalf, has paid in full.

Inspect and obtain a copy of PHI. With a few exceptions, you have the right to access and obtain a copy of the PHI that we maintain about you. If we maintain an electronic health record containing your PHI, you have the right to request to obtain the PHI in an electronic format. To inspect or obtain a copy of your PHI, you must send a written request to the Privacy Office. You may ask us to send a copy of your PHI to other individuals or entities that you designate. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request to the Privacy Office. You must include a reason that supports your request. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it.

Receive an accounting of disclosures of PHI. With the exception of certain disclosures, you have a right to receive a list of the disclosures we have made of your PHI, in the six years prior to the date of your request, to entities or individuals other than you. To request an accounting, you must submit a request in writing to the Privacy Office. Your request must specify a time period.

Request communications of PHI by alternative means or at alternative locations. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For instance, you may request that we contact you at a different residence or post office box, or via e-mail or other electronic means. Please note if you choose to receive communications from us via e-mail or other electronic means, those may not be a secure means of communication and your PHI that may be contained in our e-mails to you will not be encrypted. This means that there is risk that your PHI in the e-mails may be intercepted and read by, or disclosed to, unauthorized third parties. To request confidential communication of your PHI, you must submit a request in writing to the Privacy Office. Your request must tell us how or where you would like to be contacted. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Notification of a Breach. You have a right to be notified following a breach of your unsecured PHI, and we will notify you in accordance with applicable law.

Where to obtain forms for submitting written requests. You may obtain forms for submitting written requests by contacting the Privacy Officer at Embrace Healthcare, Privacy Office, 3675 Dolson Ct., Carroll, Ohio 43112or toll-free by telephone at (877) 816-0942.

For More Information or to Report a Problem If you have questions or would like additional information about Embrace Healthcare's privacy practices, you may contact our Privacy Officer at Embrace Healthcare's Privacy Office, 3675 Dolson Ct., Carroll, Ohio 43112 or toll-free by telephone at (877) 816-0942. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective Date This Notice is effective as of March 1, 2019.

Revised by: DAS
Revised on: 03/26/2024