WELCOME!

Welcome to your new community! Your community has chosen to use ***Guardian Pharmacy*** as their pharmacy provider and through our partnership with the community, we can deliver the best possible service and ensure you get the medications you need, when you need them, safely – and at the right price.

WHY USE GUARDIAN?

- **Cost Management** – Guardian coordinates directly with your physicians and third-party insurance providers to ensure minimal out-of-pocket medication costs
- **Billing Support** – Unlike a retail pharmacy, Guardian bills medications monthly, and their local billing staff is always ready to answer billing-related questions
- **Medicare Guidance** – The pharmacy helps you understand your Medicare Part D coverage and can offer one-on-one consultations during open enrollment
- **Clinical Support** – Guardian conducts ongoing medication reviews to ensure you're on the appropriate drug regimen
- **Compliance Packaging** – Easy-to-use packaging options, required by our community, organize your medications and minimize the risk of error
- **Timely Delivery** – Scheduled and emergency deliveries are available 24/7, eliminating trips to a local retail pharmacy
- **Integrated Technology** – Guardian's seamless integration of our community's electronic medication administration record (eMAR) system eliminates transcription errors and improves medication management

Guardian designs services to make sure you never have to worry about your medication needs. That's why your community has chosen ***Guardian Pharmacy*** as our preferred pharmacy provider.

In order receive service by *Guardian Pharmacy*, please complete the enclosed paperwork and mail or fax to the pharmacy:

Guardian Pharmacy of SE Florida
6100 Broken Sound Blvd NW Ste 1
Boca Raton, FL 33487
Phone: 800-643-8434
Fax: 954-601-2400

If you do not want to use Guardian Pharmacy as your pharmacy provider, you have the choice to opt out of our services. However, if you choose to use any pharmacy other than *Guardian,* please let your community staff know as soon as possible.

PHARMACY SERVICES AGREEMENT

Guardian Pharmacy of SE Florida
6100 Broken Sound Blvd NW Ste 1
Boca Raton, FL 33487
PHONE: 800-643-8434 * FAX: 954-601-2400

This is an agreement for pharmacy services with ***GUARDIAN PHARMACY*** and

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for GUARDIAN PHARMACY's agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Guardian Pharmacy, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by Guardian Pharmacy. Guardian Pharmacy does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, GUARDIAN PHARMACY may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize Guardian Pharmacy to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of Guardian Pharmacy supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by Guardian Pharmacy. If, for any reason, Guardian Pharmacy does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay Guardian Pharmacy directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account.
5. **PAYMENT OF BENEFITS.** I authorize Guardian Pharmacy to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to Guardian Pharmacy.
6. **ASSIGNMENT OF BENEFITS.** I authorize Guardian Pharmacy to request and collect on my behalf all public and private benefits due for the products and services supplied by Guardian Pharmacy. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Guardian Pharmacy.
7. **UNPAID INVOICES.** Guardian Pharmacy encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by Guardian Pharmacy related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Guardian Pharmacy reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to Guardian Pharmacy any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by Guardian Pharmacy I also authorize all medical personnel to disclose information to Guardian Pharmacy relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to Guardian Pharmacy to use or disclose certain aspects of my health information to: the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

I have read and understand the above terms and conditions and agree to be bound by each of them:

Signature [Resident or Responsible Party]: _____ **Date:** _____

***Return to pharmacy**

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of GUARDIAN PHARMACY's privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that GUARDIAN PHARMACY is committed to protecting my health information. I certify that I have read and understand this agreement:

_____**Resident or responsible Party Initial**

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of GUARDIAN PHARMACY's Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

_____**Resident or responsible Party Initial**

PAYMENT INFORMATION

I certify that I have received a copy of GUARDIAN PHARMACY's payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

_____**Resident or responsible Party Initial**

I understand and have reviewed all of the above documents and agree to be bound as applicable.

Signature [Resident or Responsible Party]: _____ **Date:** _____

***Return to pharmacy**

RESIDENT ENROLLMENT FORM

RESIDENT INFORMATION

RESIDENT NAME _____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# ___ - ___ - ____ DOB ___/___/____ ☐ MALE ☐ FEMALE

COMMUNITY NAME _____ APT# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: ☐ SELF ☐ SPOUSE ☐ OTHER _____

**A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE*

RESPONSIBLE PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ ☐ HOME ☐ CELL EMAIL _____

ADDRESS* _____
[STREET] [CITY] [STATE] [ZIP CODE]

MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS

SECONDARY* _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ ☐ HOME ☐ CELL EMAIL _____

SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT

RETURN TO PHARMACY

RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

A valid credit card is required to be kept on file to secure this account.

TYPE OF CARD (circle): VISA MASTERCARD AMERICAN EXPRESS DISCOVER

NAME ON CARD _____ CARD NUMBER _____

BILLING ADDRESS _____ EXPIRATION (MMYY) _____/_____

_____ SECURITY CODE _____

*VISA/MC/DISCOVER: 3 digits on back of card
*AMEX: 4 digits on front of card

Please select an option below and sign.

☐ *I wish to pay automatically by credit card each month – please enroll me in auto-pay.*

☐ *I will mail in payment by check or call to pay by phone each month, promptly after receipt of Guardian's statement.*

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE _____

PAYMENT INFORMATION

Guardian Pharmacy offers three easy and convenient ways to pay your pharmacy bills.

ONLINE BILL PAY

The online portal is flexible, easy to use, and available 24/7. Manage multiple users and accounts, monitor payment activity, view your statements and enroll in electronic statement delivery.

Create an account in our online payment portal to make a one-time payment or set up automatic recurring payments. Recurring payments take the hassle out of remembering to pay your bill by allowing you to choose the date that your monthly payment is processed. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express).

The link to the online portal is **https://guardian.account-access.net/cpo/indexGU.html** . This can also be found on your monthly statements.

PAY BY PHONE

Use our automated payment system to make a payment by phone using the access code and zip code listed on your statement. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express). Call 800-643-8434 This number can also be found on each monthly statement.

PAY BY MAIL

Mail in a check or money order payment directly to the address listed on your statement to make a payment. If paying by check or money order, please include your name or account number. If I send a non-sufficient funds check, I understand and agree that Guardian Pharmacy of SE Florida may charge a forty ($40) dollar service charge and give you an opportunity to rectify the payment by sending another check without a break in service.

Pharmacy address:

Guardian Pharmacy of SE Florida
Department #0743
Guardian Pharmacy
PO Box 850001
Orlando, FL 32885-0743

If you have any questions regarding your bill or how to use one of these payment methods, please reach out to the Guardian Pharmacy billing team for assistance 800-643-8434, option #1.

FREQUENTLY ASKED QUESTIONS

❖ HOW ARE MY PRESCRIPTIONS FILLED?

After receiving prescriptions from the physician, the nursing staff at the facility calls or faxes the prescription to Guardian Pharmacy. A licensed pharmacist reviews the order to check for drug allergies, adverse interactions with other medications, and proper dosing. After several quality assurance checks, your prescription is filled and delivered, and then your medication is distributed by your community caregivers.

❖ CAN I RECEIVE CREDIT FOR MY UNUSED MEDICATIONS?

Guardian Pharmacy makes every effort to accept and issue credit for unused medications when legally possible. Guardian Pharmacy will credit back the full cost of unused medications, minus the dispensing cost, for a small restocking fee. These are some of the basic requirements to return unused medications for credit:

» The medication must be individually packaged and sealed with the manufacturing information on the packaging.
» Credits cannot be given for medications that were billed to insurance plans or the corresponding co-pays and deductibles billed to you.

❖ HOW ARE MY MEDICATIONS PAID FOR?

There are several common methods of payment/coverage for prescription medications in the long-term care environment:

» Medicare and Medicaid provide some prescription drug coverage
» Private insurance (example Blue Cross/Blue Shield, etc.)
» Long Term Care Insurance
» Prescription Drug cards (including Medicare Part D prescription drug plans)

Any portion of medication costs not covered by insurance (such as the co-pays) will be the patient's responsibility and will be billed monthly. You are responsible for paying 100% of balance by the due date indicated on the statement. You will not be billed for the portion of costs covered by any insurance.

❖ DO YOU OFFER PHARMACY CONSULTATIONS?

Guardian Pharmacy's on-staff pharmacists are available to discuss your drug regimen. Call the pharmacy at **800-643-8434** if you have any questions or would like to schedule a consultation.

❖ WHY ARE SOME MEDICATIONS BILLED TO ME AT FULL PRICE WHEN I HAVE INSURANCE?

» ***Your insurance may have changed***
  - Guardian Pharmacy needs your most recent insurance information in order to bill accurately. Please contact our pharmacy staff as soon as possible with any changes and updated information.

» ***Your medications are over-the-counter (OTC)***
  - Many insurance plans do not cover OTC (non-prescription) medications. Exceptions are often made for insulin and diabetic supplies.

» ***You haven't met your insurance deductible***
  - Some insurance plans require an annual deductible be met before the insurance will pay. Until you meet the deductible amount, your bill will reflect the pharmaceutical expenses that are your responsibility.

» ***Your medication requires prior authorization from your insurance company***
  - Some medications prescribed by your physician may need to be reviewed by your insurance company before the costs can be covered. If this occurs, Guardian Pharmacy will coordinate directly with your physician and insurance company to ensure your medication or an alternative medication is covered.

» ***Your insurance plan has a restriction***
  - In some cases, your insurance plan might have restrictions that include, but are not limited to:
    - The quantity that can be dispensed for refill orders.
    - How long the pharmacy has to file the claims. Sometimes the insurance plan will not cover a medication if it is dispensed or billed outside of the plan parameters.
  - If there is a restriction on your medication, you are often able to file a claim with your insurance company for direct reimbursement.

» ***You're on a mail-order only prescription plan***
  - If your prescription plan is limited to mail-order medications only, the insurance company may not reimburse the pharmacy for medications dispensed. However, most plans allow a "Long-Term Care Retail Pharmacy Override," in which the insurance plan allows patients residing in a long-term care community to get medications filled at a retail pharmacy. Guardian Pharmacy is happy to assist with this if your plan allows for this.

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

As our customer, you are hereby provided this Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. We fulfill our obligation to protect and promote the rights of our patients, including the following:

RIGHTS: As the patient/caregiver, you have the right to:

- Be treated with dignity and respect
- Confidentiality of patient records and information pertaining to a patient's care
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care
- Be notified in advance of any change in your plan of care and treatment
- Be provided equipment and service in a timely manner
- Receive an itemized explanation of charges
- Be informed of company ownership
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property
- Be informed of potential reimbursement for services under Medicare, Medicaid or other 3rd party insurers based on the patient's condition and insurance eligibility
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third-party insurers. (to the best of our knowledge)
- Be notified within 30 working days of any changes in charges for which you may be liable
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed, if **Guardian Pharmacy** is unable to provide services then we will provide alternative resources
- Purchase inexpensive or routinely purchased durable medical equipment
- Expect that we will honor the manufacturer's warranty for equipment purchased from us
- Receive essential information in a language or method of communication that you can understand
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law

CLIENT RESPONSIBILITIES: As the patient/caregiver, you are RESPONSIBLE for:

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participation as in the plan of care/treatment.
- Notify the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses,
- hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

OUR RIGHTS: As your pharmacy of choice, we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our pharmacy to secure medication or durable medical equipment.
- To refuse services to anyone who enters our pharmacy and is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

NOTICE OF NON-DISCRIMINATION

Guardian Pharmacy, LLC and its related entities comply with applicable federal, state and civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected status. In addition, Guardian:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Auxiliary aids and services
- Written information in other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Guardian at 800-643-8434.

If you believe that Guardian has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or any other protected status, you can file a grievance with *Guardian's Compliance Department* by calling 1-866-827-5477.

If you feel your concern is not addressed you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

COMPLAINT PROCEDURES

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 1-866-827-5477; when you call you will be directed to a compliance specialist.

If you follow this process, we will ensure your concerns will be reviewed, investigated and responded to in accordance with state and federal regulations.

MEDICARE PATIENTS

If your concern is not addressed, you can file a complaint/or speak to a customer service representative at Medicare by calling 1-800-MEDICARE or 1-800-633-4227

HIPAA 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.

Guardian Pharmacy, LLC is required by federal and certain state regulations to safeguard the privacy of your PHI. We are also required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. This Notice applies to all information and records related to your care that Guardian has received or created.

RIGHTS OF THE PATIENT

OBTAINING INFORMATION: When it comes to your PHI, you have certain rights. You may obtain a paper copy of this Notice of Privacy Practices promptly at any time, even if you agreed to receive the notice electronically. You can ask to see or get an electronic or paper copy of your medical record and other PHI we have about you. Let us know in writing if you would like to do this. We will provide a copy or summary of your PHI, with limited exceptions, usually within 30 days of your written request. We may charge a reasonable, cost-based fee. You can request a specific method you wish to be contacted about your PHI to ensure confidential communications, such as home or office phone, or to send mail to a different address. Let us know your preference in writing. We will agree with all reasonable requests. If you believe there is PHI that is incorrect or incomplete, you can request a correction in writing. We may say "no" to your request, but we will explain why in writing within 60 days.

WITHOLDING/SHARING OF INFORMATION: You can ask for certain PHI for treatment, payment, or our operations to not be shared. We are not required to agree to your request and may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket, you can ask us not to share that information for payment purposes or our operations with your health insurer. We will agree unless a law requires us to share that information. You can request a list of the times we've shared your PHI for six years prior to the date you ask, including whom we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures excepted by law (such as any you asked us to make). We will provide one accounting per year for free, but will charge a reasonable, cost-based fee if another is requested with a 12-month time period.

Unless you tell us not to, we may share your PHI in the following ways: with family, close friends, or others involved in your care or payment for your care; in the event of a disaster relief situation; to include information in a facility directory; or in contacting you for fundraising efforts (but you can tell us not to contact you again). If you have a clear preference for how we share your information in these situations, talk to us. Tell us what you want us to do, and we will follow your instructions. If you are unable to tell us your preferences, for example if you are unconscious, we may go ahead and share your PHI if we believe it is in your best interest. We never share your PHI without your written consent in regards to marketing purposes, sale of information, or most sharing of psychotherapy notes.

ASSIGNING POWER OF ATTORNEY: If you have given someone medical power of attorney or if someone is legally authorized under law to make health care decisions on your behalf, that person can exercise your rights and make choices about your PHI. We will make sure the person has this authority and can act for you before we take any action.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment and Public Health: We can share your PHI in certain situations regarding your treatment or public health. These may include sharing your PHI with other professionals such as pharmacists, doctors, nurses, technicians and other personnel involved in your health care (for example, a doctor prescribing medications for you may need to know what other medications you are taking to protect against harmful drug interactions). 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. For example, we may share your medical information to contact another health care provider to refill a prescription or with your community/facility to follow-up on your care. Overall, this helps us 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. We may also share information about you to prevent disease, help with product recalls, report adverse reactions to medications, report suspected abuse, neglect, or domestic violence, or prevent a serious threat to anyone's health or safety.

PAYMENT: We can use and share your PHI to bill and get payment from health plans or other entities, such as giving information to your health insurance plan so it will pay for your services. For example, we may share your information about what medications were provided to you with your insurance plan, so that we may be paid or reimbursed for your medications. We may also tell your health insurance company about a prescription that you need to obtain prior approval or check if your insurance will pay for the medication you or your physician has requested.

OPERATE OUR PRACTICE: We can use and share your health information to run our pharmacy, improve your care, and contact you when necessary. For example, we may use health information about you to conduct quality assessment and improvement activities or to review the competence or qualifications of health care professionals. When an individual dies, we can share that individual's PHI with a coroner, medical examiner, or funeral director. We can also share PHI for communications between other administrations such as organ procurement organizations, health research, workers' compensation claims, law enforcement purposes, health oversight agencies, or special government functions such as military, national security, and presidential protective services. We can also disclose PHI in response to a court or administrative order or subpoena or when state or federal law requires it, including with the Department of Health and Human Services. We may share your information with third-party business associates, which are vendors that perform various services for us. For example, we may disclose your medical information to a vendor that provides billing or collection services for us.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your PHI, to provide you with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We will inform you timely if a breach occurs that may have compromised the privacy or security of your PHI. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your PHI other than as described here unless you give permission

in writing. If you tell us we can, you can change your mind at any time. Let us know in writing if you change your mind.

We will not share any substance abuse, mental health, genetic testing, HIV, or sexually transmissible disease records without your written permission unless specifically permitted or required by law.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our pharmacy, and on our web site.

If you have any complaints or questions about our privacy policies, please contact:

Senior Compliance Officer
Guardian Pharmacy, LLC
171 17th Street NW
Suite 1400
Atlanta, Georgia 30363

If you still feel your rights have been violated, a complaint can be filed by contacting us using the information at the end of this notice, or by filing a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. They may be reached through the mail at 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or online at www.hhs.goviocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Guardian Pharmacy Privacy Group is an Affiliated Covered Entity. If you would like additional information about state law protections in your state, or additional use or disclosure restrictions that may apply to sensitive PHI, please contact Guardian's Senior Compliance Officer.

Effective date of this notice: April 1, 2019