Medicare Counseling Consent Form - Virtual

Mission: *Senior PharmAssist promotes healthier living for older adults in Durham by helping them obtain and better manage needed medications and by providing tailored health education, Medicare insurance counseling, community referral, and advocacy. Senior PharmAssist is not a prescriber and does not prescribe medications.*

Senior PharmAssist is the Senior Health Insurance Information Program (SHIIP) site for Durham County. I certify that I am a Durham resident and that I have Medicare Part A and/or Part B or I will be eligible for Medicare soon. I am asking for Senior PharmAssist*'s* assistance with choosing a Medicare-approved drug or health plan, and I acknowledge that I understand and agree to the following:

1. Senior PharmAssist will work with me to help me better understand the drug and/or health benefits available to me. Medicare-approved and private drug and health plans can change, and my medications can be changed over time. Senior PharmAssist will work with me to sort through Medicare-approved drug or health plans to find one or two plans that seem to best suit my current needs.

2. I will not hold Senior PharmAssist responsible for the decision to join or not join a particular Medicare-approved drug or health plan or other decisions I may make about my health or prescription drug coverage. I understand that Senior PharmAssist is not responsible for problems that arise related to these privately administered plans. Senior PharmAssist is also not responsible for problems related to the Medicare website or Medicare's communication with the Social Security Administration and the insurance companies about my payment decisions.

3. If needed, I am authorizing Senior PharmAssist to assist me in creating an online MyMedicare account, or to access my current account. This is in order to create or update my drug list and compare Medicare Part D and/or Medicare Advantage plans. In addition, I am authorizing the agency to securely store the Username for MyMedicare account in order to assist me with plan comparisons or other Medicare enrollment or claims issues now and in the future upon my request. I have the right to refuse creation/access to my on-line MyMedicare account and Senior PharmAssist will have to conduct a general on-line search.

4. Senior PharmAssist may contact Medicare, state agencies, healthcare insurers, and/or review my electronic health record in order to verify and/or clarify my eligibility and coverage for prescription drug and/or health plans.

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5. Senior PharmAssist and participating pharmacies may share information concerning my medication use and health status (protected health information) with each other, my doctor, or other health care providers, and my caregiver if they are concerned about my well-being.

6. Information gathered about me at Senior PharmAssist is considered a medical record. I have the right to ask for a correction in the medical record on file at Senior PharmAssist and I may also request a copy of this medical record. Senior PharmAssist has 30 days to respond to my request. I understand that I will be asked to reimburse Senior PharmAssist if I request a copy of my medical record.

7. Senior PharmAssist may use information gathered in interviews and medication reviews for its program, and reports. My name will be kept confidential and will not be used in public reports. The information will be used only for healthcare or reimbursement related purposes.

8. If I feel that my protected health information has been shared without my permission for purposes other than treatment, payment or continuing healthcare operation, I can file a complaint with Senior PharmAssist and/or the U.S. Office of Civil Rights - www.hhs.gov/ocr/hipaa or call (866)627-7748; US DHHS, 200 Independence Ave, S.W., Room 509F, HHH Building, Washington, DC 20201.

9. This is my copy of the consent form for my personal records.

Signature: _____

Today's date: _____

If *Care partner* is involved:

Signature: _____

Name (PRINT) _____