Fulton Pharmacy, Inc. t/a

***Whitesell's Pharmacy***

***Home Medical Supplies***

**238-B North Market Street**

**Frederick, MD 21701**

P-301.663.6464 F-301.663-3207

**Breast Pump and Intake information C:\Users\QS1 ACCT\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\ASP98Z4J\MC900187819[1].wmf**

Welcome and thank you for choosing Whitesells Pharmacy. This letter is intended to help guide you in the process of obtaining a breast pump.

1. **Insurance companies require the child be born prior to ANY disbursement of breast pump**. If the child has not been born yet, you can still complete and send the required documentation to Whitesell Pharmacy, at which point it will be held until we receive notification from you that the child has been born. (If you are planning to do this, please make sure that when sending the DME packet back to us you write “**child has not been born yet**” on the packet. Also, note that it will be **YOUR** responsibility to contact us when the child has been born.)

When completing the DME intake forms:

1. Complete the form with your information. (In other words, the **mother’s information**) **Please write clearly. If not legible this may cause a delay in the process.**
2. Return the completed form along with:
   1. copy of your photo ID
   2. copy of insurance card (front & back)
   3. prescription from your doctor. The prescription needs to state “breast pump” and have the mother’s name on it.

Once **all** of the information has been received by us we will begin processing your order. All requested information can be sent back to us via fax, email or snail mail.

Please note ALL breast pumps will be shipped directly from the warehouse to your home via FedEx. Typical time to ship is between 4-5 business days from the time paper work has been processed and completed. Please note FedEx delivers up until 7pm.

Please be aware that the breast pump is not a rented item. It is yours to keep. If you have any questions regarding what your out-of-pocket cost may be for this item (if any), we suggest that you get in contact with your insurance company. You may give them billing code **E0603.**

**Breast pumps that we offer:**

1. ) **Medela Pump in Style Advanced Breastpump Starter Set**



Medela’s Pump In Style Advanced Breastpump Starter Set (part of Medela's patented 2-Phase Expression technology) includes:

Pump In Style® Advanced double electric breastpump

(1) set of tubing

(2) 24 mm PersonalFit™ breastshields

(2) valves

(2) connectors

(2) membranes

(2) 5 oz/150 mL breastmilk bottles with lids

Power adaptor

Instructions for use (English, Spanish, French)

|  |
| --- |
| * The Pump In Style Advanced Breastpump Starter Set is part of Medela's patented 2-Phase Expression technology pump family, proven to get 18%\* more milk when double pumping. It comes with a compact motor in a soft bag, adjustable speed/vacuum control, and a one-touch let-down button. The set lets you toggle between Stimulation and Expression phases for more efficient pumping sessions. The set fits perfectly into Medela’s breastpump bags (sold separately from Medela). Uses only authentic Medela spare parts. |
|  |

**Medela Pump in Style Advanced Breastpump Starter Set**

1. )

*** Spectra Baby USA S2 Breast pump***



*The Spectra S2 technology makes it possible for a mother to keep the pump set on her maximum comfortable suction level with minimal noise.*

*This* ***comfortable and effective*** *breast pump is powered by an ac adapter.*

***Contents for Basic model:***

* *Spectra S2 Hospital strength motor unit*
* *Double Milk Collection System includes: 2-24mm breast flanges, 2 wide neck milk collection bottles. Locking rings and discs, 2 valves, 2 tubing, 2 backflow protectors, and an AC Power Adapter.*
* *Vacuum range 0 ~ 300 mmHg*
* *Expression mode cycles/minute 38-54 RPM/Let-down mode-70 RPM*
* *Weight – less than 4lbs.*
* *Two year Warranty*

***This pump has been trialed and tested by lactation consultants and has been found to rival even the most elite of hospital grade breast pumps. Try it and you will see why nothing on the market today can compete with the S2 Hospital Strength Breast Pump!***

The S2 boasts so many great features and is designed to truly meet the needs of moms wanting to feel confident that they have an effective, powerful breast pump to support supply while also incorporating features to make life a little easier. Like all Spectra pumps, the S2 is a closed system - a physical barrier between the milk and the pump ensures hygiene and motor performance. The S2 is intended to rival ANY and ALL other hospital grade breast pumps, and even surpass them with some of its innovative features designed to make life easier for moms. With a maximum suction strength of 300mmHg and the ability to be used as a single or double pump, plus a host of additional features, the S2 is set to become the ultimate breast pump to support moms. Completely flexible, touch button with the S2 pump's digital controls. These allow you to set the pumping program to the speed and rhythm most effective for your body. The pump has 'massage mode', a short, shallow mode designed to stimulate mom’s letdown reflex (start the milk flowing). The pump can then be switched to expression mode, a deeper, slower pattern of suction which mimics how a baby nurses when the milk is flowing. The suction is adjustable in both let-down and expression mode! Includes a timer and nightlight. This pump is also really quiet!! *Ideal for rental or retail use.*

***Features: Backflow Protection***

* *Helps protect breast milk and baby from bacteria, mold and viruses while pumping.*
* *Keeps tubing dry by preventing air flow between expressed milk and pump tubing while pumping.*
* *No need to clean the narrow tubing.*
* ***Customize Your Pumping Experience*** *– 2 Phase Cycling with Let-Down Button. Completely Adjustable Suction and Cycling in let-down and expression mode.*
* *Each mother can customize her pump’s settings to her own body’s response and follow her flow to find her own best settings every time.*

3.) Ameda Purely Yours Ultra™ Personal Double Electric Breast Pump

with Tote, and CustomFit™ Breast Flanges

SKU # 17085A



This comfortable and effective breast pump motor weighs only 1 lb. It can be conveniently powered by AC Adapter (included . Batteries available separately.

Includes upscale and contemporary ultra suede and faux leather bag, discreetly storing all your pumping essentials. Easy-clean interior features pockets and dividers to keep you organized while on the go.

**Contents:**

• Purely Yours Ultra Breast Pump motor unit

• Dual HygieniKit® Milk Collection System includes: (2) 25.0mm breast flanges, (2) diaphragms, (4) valves, (2) tubing, (2) adapter caps, (1) white connector for single or dual pumping

• Ultra Suede/Faux Leather Stylish Tote

• CustomFitTM Breast Flanges, (2) 30.5mm flanges and (2) 28.5mm reducing inserts

• Cool‘N Carry™ Tote: (1) insulated carry bag, (6) 4 oz. bottles with lock-tight lids, (3) cooling elements, Milk Storage Guidelines card

• NoShow Premium™ Disposable Nursing Pads 2 pk Sample

• Store‘N Pour™ Milk Storage Bags 2 pk Sample

• AC power adapter

• Instructions for Use

• Instructional DVD

** **

**Features**

**Proven Airlock Protection**™

• The **world’s only proven** protective barrier.

• Solid barrier prevents moisture in tubing to help protect breast milk from bacteria, mold and

viruses while pumping.1

**CustomControl™**

• Independent Speed and Suction controls make it possible for mothers to achieve a *multi-phase* experience.

• Each mother can

customize her pump’s settings to her own body’s response and follow her flow to find her own best settings every time.

**Whitesell Pharmacy Home Medical Supplies contact information:**

If you should have any questions regarding ANY of this information please feel free to call us at 301-663-6464, ext.110

  - Fax: 301-663-3207

  - Email: Kathy Curran- kcurran[@whitesells.com](mailto:jfisher@whitesells.com)

  - Mail to: Whitesell Pharmacy

Home Medical Supplies

Attention: Kathy Curran

238-B N. Market St.

Frederick, MD  21701

[](http://www.google.com/imgres?start=150&biw=1438&bih=677&tbm=isch&tbnid=h7Y5WykJN5KhdM:&imgrefurl=http://www.cakechooser.com/565/congrats-joy-&-david-crafting-creatures/CAd3d3LmZ1bm55YmlydGhkYXl3aXNoZXMuaW5mby93cC1jb250ZW50L3VwbG9hZHMvMjAxMy8wNC9mdW5ueS1iaXJ0aGRheS1jYXJkLWN1dGUtYW5pbWFsLmdpZg/&docid=ufP56H7NaAxX2M&imgurl=http://ohiok.com/img/babyj3nb/moocomments/new-baby/congratulations-baby.gif&w=400&h=308&ei=6IONUtTPKtXJ4APe5oCoAQ&zoom=1&ved=1t:3588,r:73,s:100,i:223&iact=rc&page=7&tbnh=194&tbnw=252&ndsp=27&tx=235.10528564453125&ty=148)

**WHITESELL PHARMACY HOME MEDICAL SUPPLIES - BREAST PUMP INTAKE FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | First: | | | | | | | | | | Middle: | | | | ❑ Mr.  ❑ Mrs. | | ❑ Miss  ❑ Ms. | | | | | | Marital status (circle one) | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | |
| Is this your legal name? | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | Birth date: | | | | | | | | Age: | | Sex: | | | |
| ❑ Yes | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | / / | | | | | | | |  | | ❑ M | | | ❑ F |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | Home phone no.: | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | ( ) | | | | | | | | | |
| Alternate phone:  Cell ( ) | | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | ZIP Code: | | | | | | | |
| Work ( ) | | | | | | | | | **Email address:** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | |
| Occupation: | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | |
| **Breast Pump Recipients ONLY: Complete one of the dates ->** | | | | | | | | | **Baby’s Due Date: / /** (or) **Baby’s Date of Birth: / /** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | |
| Chose Whitesell’s because/ Referred to Whitesell’s by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | ❑ Insurance Plan | | | | | | | ❑ Hospital | |
| ❑ Family | | ❑ Friend | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | ❑ Yellow Pages | | | | | | | | | | ❑ Other | | | |  | | | | | | | | | | | | |
| **OB** Physician Information: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **(If you are providing a copy of the front & back of your Insurance cards, then you do not need to complete this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | |
|  | | | | | | | / / | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | |
| Is this person a patient here? | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Occupation: | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | |
|  | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance: | | | |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | |  | | | | | | |
| Subscriber’s name: | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | Birth date: | | | | | | | Group no.: | | | | | | | | Policy no.: | | | | | | | | Co-payment: | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | / / | | | | | | |  | | | | | | | |  | | | | | | | | $ | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | ❑ Child | | | | ❑ Other | | | |  | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | Policy no.: | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | ❑ Child | | | | ❑ Other | | | |  | | | | | | | | | | | | | | |

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| IN CASE OF EMERGENCY | | | | | | | |
| Name of local friend or relative (not living at same address): | | Relationship to patient: | | Home phone no.: | | Work phone no.: | |
|  | |  | | ( ) | | ( ) | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Whitesell Pharmacy. I understand that I am financially responsible for any balance. I also authorize Whitesell Pharmacy or insurance company to release any information required to process my claims. | | | | | | | |
|  |  | |  | |  | |  |
|  | Patient/Guardian signature | |  | | Date | |  |

**Breast Pump choice selected**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this information is vital for processing Beneficiary prescriptions and will remain confidential.

\*\* Please be advised if you are purchasing durable medical equipment some items may be excluded from your insurance policy benefits. If this occurs and the insurance company does not cover these items, or if there is a co-pay associated with your coverage, the policy holder (unless the responsible party is otherwise indicated) will be responsible for all payments and will be billed directly from WHITESELL PHARMACY. Note: We may require a valid credit card or bank debit card prior to releasing the DME product to the customer, to ensure payment.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize WHITESELL PHARMACY to receive insurance benefits for the above mentioned DME item. I also agree to pay WHITESELL PHARMACY for the amount not covered by my insurance policy, including co-pays and deductibles. I have also received a copy of the CMS MEDICARE DMEPOS SUPPLIER STANDARDS notice. I understand that all the protected health information that I disclose to WHITESELL PHARMACY is protected under that privacy and security standards issued by the Health Insurance Portability and Accountability Act (HIPAA). I have the right to request information regarding the privacy and security of my disclosed Protected Health Information.

I understand that DME equipment is non-returnable.

**\_\_\_\_\_\_ I have received a copy of the Privacy Act Notice.**

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Other / Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whitesell Pharmacy**

**236 North Market Street**

**Frederick, MD 21701**

**301-662-4848**

**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.**

DATE OF NOTICE:  *June 25, 2006*

SECTION A: Uses and Disclosures of Protected Health Information

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

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

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

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

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

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

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

From time to time we may employ the services of business associates who may assist us in one or more tasks and who may use, change or create Protected Health Information. Business associates to whom a medical record is disclosed may not redisclose the medical record to another person or entity without authorization from the patient unless the disclosure is permitted by the Confidentiality of Medical Records Act (CMRA) for purposes of reporting child abuse or is directory information.

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

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

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

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

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

***Whitesell’s Pharmacy, Privacy Officer***

***236 North Market Street***

***Frederick, MD 21701***

**301-662-4848**

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

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

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

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

Section B: Contacting Us

You may contact us for further information at:

***Whitesell’s Pharmacy***

***Privacy Officer***

***236 North Market Street***

***Frederick, MD 21701***

***Phone: 301-662-4848, Fax: 301-620-0668***