**Breast Pump and Intake information**

Welcome and thank you for choosing Home Medical Supply. 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 the Postal Service.

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.**

**Whitesell Home Medical Supply contact information:**

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

  - Fax: 301-663-3207

  - Email: K.J Rippeon - krippeon@whitesells.com   
               
  - Mail to: Whitesell Home Medical Supply

Attention: K.J Rippeon

622 N. Market St.

Frederick, MD  21701

***On behalf of the team of Whitesell Home Medical Supply, we would like to congradulate you on your new bundle of joy!***

**Breast pumps that we offer:**

**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. |
| **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.*

**Ameda Finesse Breast Pump**



“Ameda’s brand new Finesse pump mimics their Ameda Platinum®  multi-user hospital pump waveform in a discreet, personal pump and is designed for daily use.”

Features include:

* Comfortflow™ technology for a smooth and more consistent sensation, meaning more milk
* Quiet Technology
* [HygieniKit® Milk Collection System](https://www.ameda.com/product/finesse-breast-pump/#hygienikit-popup): Proven FDA-cleared barrier designed to protect pump, tubing and bottle against mold and viruses
* Separate speed and suction dials with 32 fully customizable options for multiphase pumping
* Adaptable for single or double pumping
* Easy-to-clean surface, contemporary look
* Power with AC adapter (included) or AA batteries (not included) for worry-free access to pumping
* 2-year warranty

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | D.O.B: | | | Age: | | Sex: |
| Yes No |  | | | | | |  | | / / | | |  | | M F |
| Street Address: | | | | | | | Social Security Number: | | | | | Home Phone Number: | | |
|  | | | | | | |  | | | | | ( ) | | |
| City: | State: | | | | | | Zip Code: | | Ht: | | Wt: | Alternate Phone: | | |
|  |  | | | | | |  | |  | |  | Cell: ( ) | | |
| Occupation: | Employer: | | | | | | Employer Phone Number: | | | | | Work: ( ) | | |
|  |  | | | | | | ( ) | | | | |  | | |
| Chose Whitesell’s because/Referred to Whitesell’s by (please circle) | | | | | | | | | | | | | | |
| Physician Insurance Plan Hospital Family Friend Close to work/home Yellow Pages Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Primary Physician Information: | | | | | | | Date of Last Office Visit: | | | | | | | |
|  | | | | | | |  | | | | | | | |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **Breast Pump Recipents Only:**  **Complete one of the dates:** | | | | | | | | **Baby’s Due Date**: / /  **Baby’s Date of Birth**: / / | | | | | | |
| **Breast Pump Choice Selected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Insurance Information** | | | | | | | | | | | | | | |
| (Please give your insurance card to a member of our staff) | | | | | | | | | | | | | | |
| Person responsible for Bill: | | | | D.O.B | Address if different than above: | | | | | | | | Home Phone Number: | |
|  | | | | / / |  | | | | | | | |  | |
| 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: | | | | Subscriber’s D.O.B: | | | | Policy Number: | | | | |
|  | |  | | | | / / | | | |  | | | | |
| Group Number: | | Co-payment | | | Patient’s relationship to subscriber: | | | | | | | | | |
|  | | $ | | | Self Spouse Child Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Secondary Insurance:** | | | | | | | | | | | | | | |
| Subscriber’s Name: | | Subscriber’s S.S No: | | | | Subscriber’s D.O.B: | | | | Policy Number: | | | | |
|  | |  | | | | / / | | | |  | | | | |
| Group Number: | | Co-payment | | | Patient’s relationship to subscriber: | | | | | | | | | |
|  | | $ | | | Self Spouse Child Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be pain directly to the Whitesell Home Medical Supply. I understand that I am financially responsible for any balance. I also authorize Whitesell Home Medical Supply or insurance company to release any information to process my claims. | | | | | | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient/Guardian Signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient/Guardian Printed Name:** | | | | | | | | | | | | | **Date:** / / | |

**Financial Responsibility and Consent Notice**

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

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize WHITESELL HOME MEDICAL SUPPLY to receive insurance benefits for the above mentioned DME item. I also agree to pay WHITESELL HOME MEDICAL SUPPLY for the amount not covered by my insurance policy including co-pays and deductibles. I understand that all the protected health information that I disclose to WHITESELL’S HOME MEDICAL SUPPLY is protected under the privacy and security standards issued by the *Health Insurance Portability and Accountability Act (HIPPA*). 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 understand that failure to pay any outstanding balances on my account for items purchased from WHITESELL HOME MEDICAL SUPPLY after **120 days** of initial billing date will be assigned to a collection agency for purposes of payment collection. If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 8%, court costs, and attorney fees, as allowed by law.

I understand that we, as WHITESELL HOME MEDICAL SUPPLY, our agents or assignees may call by telephone regarding your account. You agree that we, our agents or assignees may place such calls using an automatic dialing/announcing device. You agree that we, our agents or assignees, may make such calls to any telephone number you have provided including any mobile telephone or similar device. You agree that we, our agents or assignees may, for training purpose or to evaluate the quality of service, may listen to and record phone conversation you have with us and/or agents or assignees.

\_\_\_\_\_ I have received a copy of the *Patient Bill of Rights and Responsibilities*

(Whitesell HMS Employee Initials :\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_ I have received a copy of the *Notice of Privacy Practices* (Whitesell HMS Employee Initials :\_\_\_\_\_\_\_\_\_)

Patient’s Signature (SEAL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Other / Relationship (SEAL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Bill of Rights and Responsibilities**

To ensure the finest care possible, as a Patient receiving Durable Medical Equipment (DME) and our Pharmacy services, you should understand your role, rights and responsibilities involved in your own plan of care.

**Patient Rights**

* To select those who provide you with DME and Pharmacy Services
* To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preferences or physical or mental handicap
* To be treated with friendliness, courtesy and respect by each and every individual representing our Pharmacy, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
* To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible your current needs, including management of pain
* To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination services
* To express concerns, grievances or recommend modifications to your DME and Pharmacy services, without fear of discrimination or reprisal
* To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatment, risk of treatment, alternative treatments, risk of treatments or care plans.
* To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Pharmacy’s policies, procedures and charges
* To request and receive data regarding treatment, services or costs thereof, privately and with confidentially
* To be given information as it relates to the uses and disclosure of your plan of care
* To have your plan of care remain private and confidential, except as required and permitted by law

**Patient Responsibilities**

* To provide accurate and complete information regarding your past and present medical history
* To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
* To participate in the development and updating of plan of care
* To communicate whether you clearly comprehend the course of treatment and plan of care
* To comply with the plan of care and clinical instructions
* To accept responsibility for your actions, if refusing treatment or not complying with the prescribed treatment and services
* To respect the rights of Pharmacy personnel
* To notify your Physician and the Pharmacy with any potential side effects and/or complications

**Whitesell Pharmacy and Home Medical Supply**

HIPPA Notice of Privacy Practices

Date of Notice: August 2013

©2013 All Rights Reserved by PharmCAP, LLC. HIPPA Notice of Privacy Practices – August 2013

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

When this Notice of Privacy Practices (“Notice”) refers to “we” or “us,” it is referring *to Whitesell Pharmacy and Home Medical Supply* and all pharmacists who provide health care services and the employees of our pharmacy. We are required by law to maintain the privacy of your protected health information (“PHI”), to follow the terms of the Notice currently in effect, to give you this Notice setting for our legal duties and privacy practices concerning your PHI and to notify affected individuals following a breach of unsecured PHI. This notice describes how we may use and disclose your PHI. Additionally, this Notice explains the rights you have with respect to your PHI, and certain obligations we must abide by in accordance with the law. We reserve the right to amend this Notice. If we make any material revisions to this Notice, we will post a copy of the revised in the pharmacy, home medical supply retail store, on our website and will off you a copy of the revised Notice.

1. **USE AND DISCLOSURE OF YOUR PHI** - We will use and disclose your PHI for treatment, payment and health care operations. We may also use your PHI for other purposes that are permitted and/or required by law and pursuant to your written authorization. The following lists examples of how we may use and/or disclose your PHI. Any other uses not described in this Notice will only be made with your explicit written authorization, which you may revoke at any time by providing us with written notice of your revocation.
2. Treatment - We may use and disclose your PHI in order to provide you with prescription and supply services. We may disclose your PHI to other pharmacists, pharmacy technicians and health care providers that are involved in your care. You will receive an individual notice and have the opportunity to opt out of any subsidized treatment communications.
3. Payment - We will use and disclose your PHI in order to obtain payment for the health care services we provide to you. We may also need to disclose your PHI to receive prior approval from your health plan or to determine if your health plan will cover a certain prescription or service.
4. Health Care Operations - We may use and disclose your PHI in connection with the management of our pharmacy. For example, this may include: quality assessment and improvement, internal compliance audits, and performance evaluations. Additionally, we may use your PHI for our business management and general administrative activities.
5. Prescription Refill Reminders, Treatment Alternatives or Health-Related Benefits - We may use and disclose your PHI to contact you to remind you about prescription refills, to tell you about treatment options or alternatives, or to inform you about health-related benefits or services that may be of interest to you.
6. Family Members, Relatives or Close Friends - Unless you object to such disclosure, we may disclose your PHI to your family members, relatives or close personal friends, or any other persons identified by you as being involved in the treatment or payment for your medical care. If you are not present to agree or object to our disclosure of your PHI to a family member, relative or friend, we may exercise our professional judgment to determine whether the disclosure is in your best interest. If we decide to disclose your PHI, we will only disclose the PHI that is relevant to your treatment or payment.
7. Other Permitted and Required Uses and Disclosures - We may use your PHI without obtaining your authorization and without offering you the opportunity to agree or object as follows:
   * as required by law, provided however, that the use or disclosure will be made in compliance with applicable law;
   * to a public health authority that is authorized by law to collect or receive such information, or to a foreign government agency that is acting in collaboration with a public health authority and these health activities generally include preventing or controlling disease, reporting deaths, reporting adverse effects of medications or problems with products, notification of communicable disease, and reporting abuse or neglect under certain circumstances;
   * to a health oversight agency for oversight activities authorized by law, including audits and inspections, and civil, administrative or criminal investigations, proceedings or actions;
   * for judicial or administrative proceedings purposes in response to a subpoena, court order, discovery request, etc. but only if efforts have been made to inform you about the request or to obtain an order protecting the information requested;
   * to law enforcement to report certain injuries, comply with court orders or warrants or similar process, to identify a suspect, fugitive, missing person or victim or to report a crime;
   * to a coroner or medical examiner to perform duties authorized by law such as identification of a deceased person or determining the cause of death;
   * to funeral directors, consistent with applicable law, as necessary to carry out their duties;
   * to organ procurement organizations or similar entities for the purpose of facilitating organ, eye or tissue donation and transplantation;
   * for research purposes provided that certain approvals take place and assurances are given;
   * to avert a serious threat to health or safety, so long as the disclosure is only to a person who is reasonably able to prevent or lessen such threat;
   * for military and veterans activities (including foreign military personnel) to assure the proper execution of a military mission and to determine eligibility for benefits;
   * for national security and intelligence activities for the purpose of conducting lawful intelligence, counterintelligence and other national security activities;
   * for protection of the President and other authorized persons or foreign heads of state or to conduct authorized investigations;
   * to a correctional institution or law enforcement custodian if you are an inmate or under custody; and
   * to the extent necessary to comply with laws relating to workers' compensation and work-related injuries.
8. **YOUR RIGHTS AS OUR PATIENT** - As our patient, you have a number of rights associated with you PHI. The following describes your specific rights.
9. You have the right to request restrictions or limitations on how we use and/or disclose your PHI, however, we do not have to agree to your requested restriction or limitation (except for transactions you paid for in full out-ofpocket). Your written request must specify: (1) if you would like to restrict or limit our use and/or disclosure; (2) what information you want restricted or limited; and (3) to whom the restriction or limitation applies (e.g., spouse). If we agree to your request, it will not prevent us from disclosing your PHI as follows: (1) to you if you request access or an accounting of disclosures; (2) for purposes required or permitted by law; or (3) in case of an emergency
10. You have the right to receive confidential communications concerning your PHI by alternative means or via alternative locations. For example, you may want to receive communications related to your prescriptions at a different address other than your home address. If you wish to receive confidential communications via alternative means or locations, please submit your request in writing to the Privacy Officer and set forth the alternative means by which you wish to receive communications or the alternative location at which you wish to receive such communications. We will accommodate all reasonable requests.
11. You have the right to access, inspect and obtain a copy of your PHI, including any electronic PHI; provided, however, you are not entitled to access certain PHI exempted under HIPAA. To the extent we maintain electronic PHI, upon request we will provide you with a copy of your PHI in the format requested. If we do not have your PHI in our possession, we will provide you with the appropriate contact information when your request is received. If you request a copy of your PHI, you will receive a response to your request in a timely fashion but may be charged a reasonable, cost-based fee to cover copy costs and postage. In some limited circumstances, we may deny your request for access to PHI in which case you may request for the denial to be reviewed. If access is ultimately denied, you are entitled to a written explanation with the reason(s) for the denial.
12. You have the right to receive an accounting of disclosures of your PHI made by us, including disclosures to or by our business associate(s), for a period of six (6) years prior to the date on which you request an accounting of disclosures, or such lesser period as you indicate. You will receive one request annually free of charge and, thereafter, we may charge you a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same twelve-month period. We will notify you of the cost for an accounting of disclosures and you may choose to withdraw or modify your request before we charge you.
13. If you believe we have PHI about you that is incorrect or incomplete, you may make a written request to us stating the reasons to support any requested amendment. You have the right to request an amendment to your PHI for so long as we maintain your PHI. If we do not have your PHI in our possession, we will provide you with the appropriate contact information when we receive your request. We will respond to your request for an amendment after we receive your request. However, we may deny your request for amendment if, for example, we determine that the PHI you requested was not created by us or is already accurate and complete. You may respond to our denial by filing a written statement of disagreement, but we have the right to rebut your disagreement. If this occurs, you have the right to request that your original request, our denial, your statement of disagreement, and our rebuttal be included in future disclosures of your PHI.
14. You have the right at any time to obtain a paper copy of this Notice, even if you receive this Notice electronically. If you have received an electronic copy of this Notice, but wish to obtain a paper copy of this Notice, please send your request in writing to the Privacy Officer at the address listed below.
15. You have the right to opt-out of fundraising and your PHI will not be used for fundraising purposes or sold without your prior authorization.
16. **ADDITONAL INFORMATION/QUESTIONS OR COMPLAINTS**
17. If you need any additional information about this Notice or wish to exercise any of your rights set forth in this Notice, please contact the *Privacy Officer* at the following address:

Whitesell Pharmacy,

236 North Market Street,

Frederick, MD 21701

P: 301.662.4848; F: 301.620.0668

If you believe your privacy rights have been violated, you may file a complaint without retaliation with the Privacy Officer of the Pharmacy or with:

Secretary of the Department of Health and Human Services

200 Independence Ave SW

Washington D.C. 20201