RESIDENT/RESPONSIBLE PARTY AGREEMENT

Community: _____ **BILLING INFORMATION**

Room_____ Resident: _____ **O** M **O** F

____/____/_____ _____-_____-_____ _____

DOB SSN # Medicare ID Number

_____ _____

Name of Person to Be Billed Relationship to Resident

Address of Person to Be Billed: _____

City: _____ State:_____ Zip: _____

Phone # of Person to Be Billed: _____ Cell #_____

Prescription Drug Insurance Information

O Private **O** Third-Party Insurance **O** Medicare **O** Medicaid **O** V/A

Prescription Insurance Name _____

(Please provide a copy of your prescription card)

Cardholder ID# _____ RX Bin_____ Rx PCN _____

RX Group _____ Relationship to cardholder **O** Self **O** Spouse **O** Other _____

Payment Options

O Mail me a monthly statement and I will mail in payment by check each month

O E-Mail me a monthly statement for monthly on-line or mail in payments

To: _____

O I wish to pay automatically by credit card each month—enroll me in auto pay

Credit Card **O** Visa **O** MasterCard **O** Amex **O** Discover

Card No _____ Exp Date:_____/_____

CVS No •• (4 digits - American Express all others 3 digits) _____

_____

(Signature) (Date

TMC
THE MEDICINE CHEST

Community_____ Resident: _____

2468 US HWY 441 Unit 204, Fruitland Park, FL 34731 **Phone**: 352-415-0505 **Fax**: 352-775-3329

Service Authorization Form

With my signature, I attest that the information provided in this document is true and complete to the best of my knowledge, and stipulate that I have read, understand and agree to the following:

- The facility of residence is authorized to order medications and supplies for the named resident/patient. The Medicine Chest Pharmacy LTC is authorized to fill those medications for the facility The use of The Medicine Chest as a provider of pharmaceuticals and supplies is optional.
- The Medicine Chest requires a credit card to secure all new accounts. Failure to provide credit card may result in The Medicine Chest being unable to provide medications to the resident.
- Medication dispensed to, and accepted by the facility, is not eligible for credit even if the medication is discontinued on the day of delivery or the patient leaves the facility for any reason on the day of delivery. Medications not delivered or refused from delivery for the above stated reasons may be eligible for a credit if they were never out of the custody of The Medicine Chest Pharmacy LTC or its employees. The exception being that, medications dispensed in divided doses or as crushed does are not eligible for credit at all. A restocking fee will be deducted from any credit to offset the expense of preparing the medication and processing the credit. This credit is at the discretion of the pharmacy and is done as a courtesy.
- As per Medicare requirements, a Complaint Resolution form is available from the pharmacy upon request. This request may be obtained by calling the pharmacy at 352-415-0505 and may be submitted to Yuval Levy Compliance Officer
- I understand that should Medicare deny payment of any item submitted to them on my behalf I am personally responsible for payment of said items.
- The Medicine Chest Pharmacy LTC is authorized to submit claims to, exchange information with, and receive payments from any and all third-party providers the resident is enrolled in, with an assignment of benefits and the understanding that the co-pay amount and/or any rejected/declined claims will be billed to the residents account (unless otherwise stipulated).
- The Medicine Chest requires enlarged copies of the front and back of any and all insurance cards, including Medicaid and Medicare, as well as any and all legal appointments, such as Power of Attorney, legal guardianship, ACPS, etc. (the signature page/front page is sufficient in most cases or a summary page if there is one).
- The Medicine Chest Pharmacy LTC bills third party insurance directly whenever possible and does attempt to bill promptly and properly for services rendered; however, it is understood and agreed that should any third party insurance carrier refuse to pay for services rendered that the payment due is the sole responsibility of the patient and/or guardian.
- HIPAA disclosure: I acknowledge that I have been provided with information regarding my rights under the HIPAA act and that I have retained a copy of such for my records. I also acknowledge that unless I stipulate otherwise (in writing) I authorize The Medicine Chest Pharmacy LTC to only provide information or discuss my account with family members, POA, attending Physician or the community staff.
- I further agree to pay and reimburse The Medicine Chest Pharmacy LTC for the costs of collection incurred and for reasonable attorney's fees incurred by The Medicine Chest in the event of a customer's account is placed for collection incurred and for reasonable attorney's fees shall be limited to 30% of the principal and interest charges recovered and shall be limited to those costs actually incurred.
- I understand that the medications furnished to the above-named resident are not packaged in child-proof containers
- I will pay the entire amount due within terms of the statement in accordance with each statement. The account balance is due monthly within 30 days of the statement date shown on the billing statement. I also understand that a late charge will be added to the balance owed for delinquency of 30 days or more. Unpaid balances will be charged to the credit card on file when 60 days past due.
- This agreement will remain in effect and valid until The Medicine Chest LTC Pharmacy is notified in writing that it should be terminated

Name (print): _____ Relationship to Resident: _____

Signature: _____ Date:_____

Please copy this page and keep for your records. Failure to complete, sign and return all parts of this form will result in The Medicine Chest Pharmacy LTC being unable to provide services to the resident in question.