Patient Care Pharmacy
(The Guardian Pharmacy of SWFL)

Pharmacy Services Agreement

Designate Patient Care Pharmacy As one of the following:
- ☐ Primary Pharmacy **(fill out section 1,2,3,4 & 5)**
- ☐ Emergency Pharmacy Only **(fill out sections 1, 2, 3, 4 & 5)**
- ☐ Hospice Medications Only **(fill out sections 1 & 5)**
- ☐ Profile Only/HIPPA **(fill out sections 1 & 5)**
- ☐ Repack VA/Mail Order - $15/month maintenance fee **(fill out sections 1,2,3,4 & 5)**

Facility Name: ____

City & State: ____

Phone # ____

Section # 1

Resident/Insured's Information:

Name: ____ Phone Number: ___________-___________-___________ Room:____________________

Address: ____ City: ______________________________ State: ______________ Zip: _______________

S.S.N: _____________-_____________-_____________ Date of Birth: _________/__________/___________

Section # 2

Financially Responsible Party Information (If Applicable)

Name: ____ Phone Number: ____________-____________-___________

Mobile Number: ______________-______________-______________ Work Number: _______________-_______________-________________

Address: ____ City: ______________________________ State: ___________ zip: ____________

Relationship to Insured: _________________________________ Email: ____

Section # 3

Primary Insurance Company (**please include copies of the front and back of all applicable insurance cards**)

Insurance Company Name: ____ Phone Number: __________-__________-__________

ID #: ____________________________________ Rx Group #: _____________________ Rx BIN #: _________________ Rx PCN #: _______________________

Secondary Insurance Company (**if applicable, please include copies of insurance cards**)

Insurance Company Name: ____ Phone Number: __________-__________-__________

ID #: ____________________________________ Rx Group #: _____________________ Rx BIN #: _________________ Rx PCN #: _______________________

Please be sure to complete all sections that apply to the pharmacy service you have chosen. This will help insure that the resident will be billed correctly each month. The Pharmacy billing cycle runs from the 1st of each month to the last day of the month. All statements are sent out via mail or email promptly by the 5th of the month and should be paid before or on the due date of the 20th.

CONTINUE TO NEXT PAGE TO COMPLETE AND SIGN →

Section # 4

1Payment Information: **(Please print all information)**

- ☐ Check Payment (due in full within 30 days of statement date) **Make all checks payable to – Patient Care Pharmacy**
- ☐ Automatic Payment (Monthly charges will be applied to the card listed below and a statement marked paid will be mailed or email per your choice
  - Mail Paid statement
  - Email paid statement: email address ____

Credit Card / Debit Card Billing: Credit or debit card information (Note: This confidential information will be securely maintained)

Credit Card type (circle one): Visa MasterCard Discover American Express

Patient Name: ____

Name on Card: ____

Address: ________________________ City: ______________ State: __________ Zip: __________

Card Number: ________-________-________-________ Exp. Date: ________/ ________ c.c. Number: ________

I authorize Patient Care Pharmacy to charge my credit/debit card, as preference above, each month for services for which I am financially responsible. If I dispute any of the charges, Patient Care Pharmacy will work diligently to resolve the dispute and make the appropriate financial restitution as quickly as possible.

If the Credit/ debit card is not able to fulfill payment, for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services. Patient Care Pharmacy will notify me within 10 days if my credit / debit card have been declined. Further, I agree to pay a service charge, Calculated at 1.5% per month, on all unpaid balances over thirty (30) days past due and any collections costs and/ or attorney fees incurred by Patient Care Pharmacy to recover the amount owed.

The Amount Owed is to remain in full force and effect until Patient Care Pharmacy has received written notice from me or my designee of its termination in such time and such manner as to afford Patient Care Pharmacy and the bank listed above a reasonable opportunity to act on it.

______________________________________ ______________________

Financially Responsible Signature Date

Section # 5

NOTICE OF PRIVACY PRACTICES- HIPPA

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Pease review it carefully. We are required by law to: Make sure that the medical information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to your medical information and follow the terms of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment. We may disclose medical info about you to doctors, nurses, and other health profession-also who are involved in your medical care.

For Payment. We may disclose the minimum amount of information required by your insurance company for reimbursement of your services.

For Health Care Operations. We may use this information to provide the best health care we can based on your medical information.

Law Enforcement. We may release your information if asked to do so by law enforcement officer. Examples would include a subpoena, warrant summons, fugitive material witness, missing person, victim of crime, criminal misconduct or about a death. In emergency circumstance to report a crime. ALL other disclosures require a patient's written authorization which may be revoked at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

Right to inspect and copy-you may request this at any time.

Right to Amend- you may have us update and change incorrect information

Right to Accounting Disclosures- for examples, you may request an itemized list of prescriptions that Patient Care Pharmacy has filled for you in the last 12 months

Right to Request Restrictions- for example, you may request that we not give our particular parts of your medical records to family

Right to Confidential Communications- For Example, you may request that we only contact you at home or by mail

WE RESERVE THE RIGHT TO UPDATE AND CHANGE THIS NOTICE AND POST A CORRECT VERSION OF THE NOTICE AT ALL TIMES. COMPLAINTS: all complaints about privacy violations or any other matter should be made to the Pharmacy Manager. You will not be penalized for making any complaints. You have the right to complain to the Department of Human Services about any violations of your privacy.

RECEIPT OF A COPY OF THE NOTICE OF PRIVACY PRACTICES

I HAVE READ AND UNDERSTAND MY RIGHTS AND HIPPA LAWS:

SIGNATURE ______________________________DATE: ______________

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: 1. Patient Care Pharmacy is authorized to fill medications for and the facility of residence is authorized to order medications and supplies for the above named resident/patient. 2. The use of Patient Care Pharmacy as a provider of pharmaceuticals and supplies is optional. 3. Medications 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 deliver. Medications not delivered or refused from delivery for the above stated reasons maybe eligible for credit. The credit is at the discretion of the pharmacy and is done as a courtesy. 4. As a per Medicare requirements, a Complaint Resolution form is available from the pharmacy upon request. This request may be obtained by calling the pharmacy 941-255-1987, and may be submitted to 24451 Sandhill Blvd., Unit A, Punta Gorda, FL 33983. 6. 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. 7. Patient Care Pharmacy is authorized to submit claims to, exchange information with and receive payments from any and all third-party providers the residents is enrolled in, with assignment of benefits and the understanding that the co-pay amount and/or any rejected/decline claims will be billed to the residents account (unless otherwise stipulated). 8. Patient Care Pharmacy bills third party insurance directly whenever possible and does attempt to bill promptly and properly for service 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 for the patient and/or guardian.

Name (print): ______________________________ Relationship to Resident: ______________

Signature: ______________________________ Date: ______________