



Welcome to PharmcareUSA

Our Pharmacy has been chosen to provide pharmacy services at _____ Assisted Living Facility, we will be working with your facility in providing and managing your medications while staying in the facility. PharmcareUSA pharmacies kindly ask that you sign this form to ensure that we remain in compliance with Medicare and all other governing agencies. By execution of this Agreement, I consent and/or elect PharmcareUSA as my primary pharmacy to provide my pharmacy services and understand that PharmcareUSA accepts Medicare and Medicaid business.

PATIENT DOCUMENT ACKNOWLEDGEMENT (PATIENT ADMISSION PACKET)

- PharmcareUSA Protected Health Information (can also be found on our website www.pharmcareusa.com)
PharmcareUSA Mission Statement
Billing & Collection Policies (upon request)
Grievance/complaint procedure
Patient Bill of Rights & Responsibilities Statement
Warranty/Equipment (only applicable if pharmacy provides equipment)
Supplier Standards - The products and/or services provided to you by PharmcareUSA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c).

We may need to reach you for billing questions would you please provide us with your preferred method of contact:

- Cell Phone #: _____
Text Message #: _____
Home Phone #: _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER (PERMISSION TO BILL YOUR INSURANCE)

I request that payment of authorized Medicare & other benefits be made on my behalf to PharmcareUSA for products & services that they have provided me. I further authorize a copy of this agreement to be used in place of the original & authorize any holder of medical information including medical records to be released to PharmcareUSA, as well as, any Federal, State or Accrediting Body or Agency as required by the Regulatory, Licensing or Accrediting Body, in order to determine these benefits or compliance with current healthcare standards.

Primary Insurance #: _____ Group #: _____ Effective Date: _____
Secondary Insurance #: _____ Group #: _____ Effective Date: _____

INSTRUCTIONS TO CUSTOMER/RETURN DEMONSTRATION & ACKNOWLEDGMENT

As a resident of an assisted living facility, I agree to allow the nurse/facility representative to sign/acknowledge receipt of all prescription medications and/or other equipment/supplies as well as receipt of all Patient Education materials. I have had my financial responsibilities explained to me and agree with the terms of this document.

HIPAA RELEASE (SEE HIPAA PRIVACY NOTICE INCLUDED WITH THIS PACKET)

In accordance with the HIPAA Privacy Regulations, PharmcareUSA may disclose to a member of your family, other relative, or any other person identified by you, the protected health information directly relevant to such persons involvement with your care or payment related to your health care. Please assist us by identifying below individuals who are involved in your care and/or in the payment of your care to whom a limited amount of information may be released. If there are no such individuals please indicate none.

1) _____ 2) _____ 3) _____

Please read the following carefully before signing. Your signature on this page evidences your understanding and agreement to these terms as listed. Patient personal information will be kept confidential by PharmcareUSA. Patient must notify PharmcareUSA of any medical status change such as a doctor's prescription, hospitalization, acquiring an infectious disease or change in residence. Patient agrees to notify PharmcareUSA of Advance Directives being in place and any changes thereof.

PAYMENT AGREEMENT

I understand and agree that I am responsible for ALL charges for services that are not covered by Medicare, Medicaid, or other medical insurance programs or plans, public or private, under which I am entitled to benefits. I agree to provide PharmcareUSA all documents and other information necessary for PharmcareUSA to obtain direct payment from such third party payers. I agree to pay all deductible amounts and other charges not covered by the assignment of benefits. I agree to and understand that I can obtain specific information as it relates to medication charges by directly contacting my PharmcareUSA pharmacy and or requesting my specific medication charges via sending an inquiry to my pharmacy via the PharmcareUSA website at www.pharmcareusa.com. I agree to pay a late fee of 1.5% on any balance not paid within 30 days. PharmcareUSA reserves the right at any time to discontinue services for any account with a past due balance. I understand that upon discharge from the assisted living facility, I may be responsible for payment of medications released to client/resident. I also agree to pay PharmcareUSA for all collection fees, attorney's fees, court costs, and other expenses involved in collecting any charges hereunder. The customer acknowledges that he has not received any representations of promises concerning the pharmacy services or the terms of this agreement other than as set forth herein. As a resident of an assisted living facility I agree to allow the nurse/facility representative to sign/acknowledge receipt of all equipment or services including prescription medications as well as receipt of all Patient Education materials. This agreement shall be governed by and construed in accordance with the laws (other than the conflict law rules) of the state the servicing PharmcareUSA is located. PharmcareUSA may assign this agreement to any successor to PharmcareUSA's business.

Resident Printed Name: _____ Resident Signature _____ Date ____/____/____

Patient's Agent or Representative _____
Relationship to Patient (if resident unable to sign, Legal guardian, Representative Payee, Relative, Representative of institution providing care or Assisting Governmental Agency) _____

Please mail statement to Responsible Party - (Name) _____ (Address) _____
(Town) _____ (State) _____ (Zip Code) _____