CLIENT AGREEMENT FOR SERVICES

FOR PHARMCAREUSA USE ONLY

Welcome to PharmcareUSA

Our Pharmacy has been chosen to provide pharmacy services at _____Nursing 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). These standards concern business professional and operational matters. The full text of these standards can be obtained at (Upon request we will furnish you a written copy of the standards.) https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/Providers~National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Standards%20Compliance?open&Cat=DMEPOS%20Supplier%20Standards

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. ***PharmcareUSA*** bills third-party as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowables, including charges related to delivery before the verification of insurance benefits.

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

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

INSTRUCTIONS TO CUSTOMER/RETURN DEMONSTRATION & ACKNOWLEDGMENT

As a resident of a nursing 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 from a discharge from a nursing 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 that as set forth herein. **As a resident of a nursing 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 _____ **DATE** ___/___/_____

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)_____