Client Agreement for Pharmacy Services - ALF

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 (Welcome Packet provided to facility)

- PharmcareUSA Protected Health Information (can also be found on our website www.pharmcareusa.com)
- Grievance/complaint procedure
- PharmcareUSA Mission Statement
- Billing & Collection Policies (upon request)
- 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 https://www.palmettogba.com/Palmetto/Providers

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

☐ **Cell Phone #: ___________________** ☐ **Email:__________________________** ☐ **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 & disallowable, including charges related to delivery before the verification of insurance benefits.

Primary Insurance:	**SSN/MBI:**	**BIN/PCN:**	**Date Effective:**
Secondary Insurance:	**Group/ID Number:**	**BIN/PCN:**	**Date Effective:**
Other:	**Group/ID Number:**	**BIN/PCN:**	**Date Effective:**

INSTRUCTIONS TO CUSTOMER/RETURN DEMONSTRATION & ACKNOWLEDGMENT

As a resident of a 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. State's that have specific statute related to reporting specific details related to patients receiving controlled substance prescriptions need to understand that their prescription information is being submitted to a database (PDMP, PMP) and that this prescription information may be queried by specific individuals for a limited number of purposes as authorized by state statute. Should you require more detail related to this practice please contact your PharmcareUSA pharmacy.

Online Bill Pay

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) ________