Good Value Pharmacy

# RESIDENT RESPONSIBLE PARTY AGREEMENT

## BILLING INFORMATION

NAME OF RESIDENT_____ M F DOB_____

FACILITY NAME_____

NAME OF PERSON TO BE BILLED/POA _____

***IF NOT PATIENT*** ***HOSPICE PATIENT- PROVIDE NEXT OF KIN***

ADDRESS OF PERSON TO BE BILLED/POA _____

CITY_____STATE_____ZIP_____

MOBILE PHONE OF PERSON TO BE BILLED/POA _____

HOME PHONE OF PERSON TO BE BILLED/POA _____

RELATIONSHIP TO RESIDENT_____

## PAYMENT/INSURANCE INFORMATION

☐ PRIVATE PAY ☐ PRIVATE THIRD-PARTY INSURANCE ☐ MEDICAID ☐ MEDICARE PART D

*PROVIDE COPY OF ALL INSURANCE CARDS INCLUDING MEDICARE CARD IF APPLICABLE*

MEDICARE #_____SOCIAL SECURITY NUMBER_____

PRESCRIPTION BENEFIT (IF APPLICABLE):

INSURANCE CARRIER NAME_____ ID NO._____

RX BIN_____ RXPCN_____ RX GROUP_____

**I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:**

· I agree that facility personnel are authorized to order purchases and charges on behalf of the above named resident.
· I agree to pay all charges incurred by the above-named resident that are not paid for by third party payers, including Medicaid, and additional charges for specially packaged medication.
· I will pay the entire amount due within 30 days of statement date shown on the monthly billing statement and understand that a finance charge (annual rate of 12%) will be added to the balance owed for delinquency of 30 days or more.
· I agree that in order for the residents account to remain active, payment for billed charges must be made promptly pursuant to these terms.
· I agree to pay all costs of collection, including court costs and attorneys fees, for all delinquent balances.
· I understand that the medications furnished to the above-named resident are not packaged in child-proof containers.

I consent to the release of personal and medical information to any third party payor, governmental agency providing benefits, or other person(s) entity liable for my treatment charges. In addition, I consent to a similar release of information, as shall be necessary, to initiate and continue my use of Good Value Pharmacy, other facility resources, and/or transfer to another health care facility.

►_____**DATE**_____

(Resident or responsible party/guarantor)

As a recurring monthly transaction, you may charge my Visa Mastercard Other _____

Card No: _____Expiration Date_____ CVV_____

►_____**DATE**_____

(Signature)

***Return to pharmacy prior to move-in***

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