Family Prescription Center

439 Wyandotte Street Bethlehem, PA 18015

Ph: (610) 866-0709 Fax: (610) 861-3877 Email: contact@familyprescription.com

Resident/Responsible Party Agreement

Name of Resident:_____ **Male/Female DOB** ____/___/___

Community Name: Universal Institute

Named of Person to be Billed/POA _____

Address of Person to be Billed/POA _____

City_____ **State**_____ **Zip**_____

Home Phone of Person to be Billed_____ **Resident Phone**_____

Relationship to Patient_____ **Email Address**_____

Payment / Insurance Information *(circle one)*

Private Pay **Private 3rd Party Insurance** **Medicaid** **Other**

Attach copy of front and back of insurance card and Medicare card

I Understand and Accept the Following Terms and Conditions:

- I agree that community 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 covered by 3rd party payers, including Medicaid, and additional charges for specially-packaged medications, and consultations.
- I will pay the entire amount due within 30days of the statement date shown on the monthly billing statement and understand that 2.5% or $10.00 late charge (whichever is greater) will be added to the balance owed for delinquency greater then 30days or more.
- I agree that in order for the resident's account to remain active, payment for billed charges must be made within 30days, pursuant to these terms.
- I agree to pay all costs of collection, including court costs and attorney fees for all delinquent balances
- I understand that the medications may not be packaged in child resistant packaging.
- I consent to the release of personal and medical information to any 3rd party, governmental agency providing benefits, or other person(s)/entity liable for treatment charges. In charges, I consent to a similar release of information, as shall be necessary, to initiate and continue my use of pharmacy, laboratory, or other community resources, and/or for transfer to another health care facility.
- Accounts will placed on Cash on Delivery basis for non payment of services after 60 days.
- I agree to notify Family Prescription Center **30 days in advance** of any billing changes for the above named resident. I understand I am responsible for any outstanding bills until such notification is given.

_____ _____

(resident or responsible party/guarantor) **(date)**

As a recurring transaction, you may charge my **Visa** **MasterCard** **Discover**

Card No._____ **Expiration date**_____ **3-Digit Code**_____

_____ **Date**_____

(Signature)