Client Agreement for Pharmacy Services - ALF

Welcome to Avacare Pharmacy

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. Avacare pharmacy kindly asks 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 Avacare pharmacy as my primary pharmacy to provide my pharmacy services and understand that Avacare pharmacy accepts Medicare and Medicaid business.

PATIENT DOCUMENT ACKNOWLEDGEMENT (Welcome Packet provided to facility)

- ✓ Avacare pharmacy Protected Health Information Grievance/complaint procedure
- ✓ Avacare pharmacy 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 Avacare pharmacy 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.

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

Cellphone #: ---------- EMAIL: ---------- Office phone #: ----------

Primary Insurance: ---------- SSN/MBI: ---------- BIN/PCN: ----------Date Effective: ---------

Secondry 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 details related to this practice please contact your Avacare pharmacy.

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 Avacare pahramcy all documents and other information necessary for Avacare pharmacy 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

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obtain specific information as it relates to medication charges by directly contacting Avacare pharmacy and or requesting my specific medication charges via sending an inquiry to my pharmacy via the Avacare pharmacy website at www.avacarerx.net. I agree to pay a late fee of 1.5% on any balance not paid within 30 days. Avacare pharmacy reserves the right at any time to discontinue services for any account with a past due balance. I understand that upon a discharge from a nursing facility, I may be responsible for payment of medications released to client/resident. I also agree to pay Avacare pharmacy 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 promise concerning the pharmacy services or the terms of this agreement other than 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 where the servicing Avacare pharmacy is located. Avacare pharmacy may assign this agreement to any successor to Avacare pharmacy 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)----------