108 WEST 1325 NORTH
CEDAR CITY, UT 84720
PHONE: 435-867-0800

Guarantor Information (Responsible Party for Resident)

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone_____

Method of Payment **REQUIRED**(circle one) Visa MasterCard Discover AMEX
Card Number: _____Expiration: _____CVV: _____

Cardholder's Signature: _____ Zip Code_____

Authorized Transaction: To allow for the payment of the medicine prescribed to be charged to the credit card listed above as approved by the facility and/or Guarantor. Township Pharmacy reserves the right at any time to discontinue service to the resident for any account with a past due balance, or a lack of funds. I understand that medications will automatically be dispensed and delivered at a fee of $20.00 per month or $5.00 per week if less than 1 month of service. I agree that should the resident be discharged from the facility it is my responsibility to notify Township Pharmacy and satisfy any debts remaining. I agree to be responsible for payment of these medications.

Guarantor Signature: _____ Date: _____

Pharmacy Staff (print)_____& Sign_____

I, agree to pay for the individuals listed above, all costs of the prescriptions, bubble packaging, and services From Township Professional Pharmacy. I am providing a credit/debit card number for the pharmacy to bill me for the excess costs and the medications. I authorize Township Professional Pharmacy to Process and charge my credit card for any balance that I may owe them. I, the patient, or responsible person for the patient, agree that I will be financially responsible for any co---pay, cost, and any non-insurance covered costs. I agree to notify Township Professional Pharmacy of any changes in my name, address, or credit/debit card information as stated above.

X_____

Patient/Resident name Print Signature Date

X_____

Responsibility/Guarantor Print Signature Date