FOX HILLS MEDI-MART and
SOMERSET SPECIALTY & LTC PHARMACY
RESIDENT REGISTRATION FORM

FOX HILLS: (248) 858-2225
SOMERSET: (248) 237-4455

FACILITY: _____ **ROOM NO:** _____

DATE MEDICATIONS ARE REQUIRED (START DATE): / /

RESIDENT INFORMATION

_____
NAME

_____
SOCIAL SECURITY NUMBER

_____
BIRTHDATE

KNOWN ALLERGIES:

_____

_____

INSURANCE INFORMATION

Include copy of the following

1. **Prescription Drug Card**
2. **Medicare Card**

PHYSICIAN INFORMATION

DOCTOR: _____

_____ _____
TELEPHONE NUMBER FAX NUMBER

RESIDENT'S REPRESENTATIVE

_____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP CODE
TELEPHONE NUMBERS:

_____ _____
HOME OTHER

BILLING INFORMATION

SEND INVOICE TO: [ ] RESIDENT [ ] REPRESENTATIVE

OR
OTHER

_____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP CODE

TELEPHONE NO.: _____

AGREEMENT AND ACKNOWLEDGEMENT

RECEIPT OF IMPORTANT INFORMATION NOTICES:

By signing below, I acknowledge that I have received a copy of the Notice of Health Information Privacy Practices of Medi-Mart Pharmacy, Patient Rights & Responsibilities, 30 Medicare Supplier Standards, Service Availability, FAQ, Medicare Drug Coverage Rights, Complaint Form, Registration Form, Intake and Authorization Forms, Warranty.

AGREEMENT TO PAY – FOX HILLS MEDI-MART, LTD (A/K/A MEDI-MART PHARMACY):

I understand that by signing this agreement I accept full responsibility for payment of the charges incurred, by me or the person for whom I am financially responsible, for services or goods received. I understand that Medi-Mart Pharmacy will attempt to the best of it's ability to obtain reimbursement for said services or goods directly from my insurance carrier or Medicare, if applicable, but that I will be liable for all deductibles, co-payments, and goods or services not covered by my insurance or Medicare, unless such liability is expressly waived by State or Federal law. I agree to pay reasonable attorney's fees and costs of collection for any past due patient balances if this account is referred to an attorney for collection.

PAYMENT IS DUE THIRTY (30) DAYS FROM DATE OF INVOICE:

A late charge of 1 ½ percent per month, 18 percent per annum, (minimum charge of 50 cents), will be assessed for late payments.

By: _____ _____ _____
Print Signature Date