****DO NOT STORE IN RESIDENT'S CHART****

PHARMACEUTICALS PURCHASE AGREEMENT

Guardian Pharmacy of SWFL
4873 Plantation Blvd., North Port, FL 34289 Office: 941-255-1987 Fax: 941-629-5507

This is an agreement for pharmacy services with Guardian Pharmacy of SWFL

_____ and _____
(Resident) (Responsible Party other than resident)

_____ _____
Social Security Number **Facility Name**

I agree to pay for any purchases made. I agree to pay the entire amount due within 15 days of the statement date shown. I authorize facility personnel to make purchases on this account on behalf of the named resident. For Mail Order repackaged medications, a repacking fee per medication per month will be billed to your account. I understand that finance charges of 1.5% per month may be charged on all past due balances over 30 days. I understand that the use of Guardian Pharmacy as a provider of pharmaceuticals and other necessities is optional. Guardian reserves the right to withhold services if payment is 30 days or more past due and no good faith effort has been made to get the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

https://guardianpharmacyswfl.com/hipaa-privacy-policy/

☐ **I certify that I have had an opportunity to review Guardian's Privacy Notice at the above listed internet link and ask questions to assist me in understanding the rights relative to the protection of the above-named person's health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.**

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Signed Responsible Party: _____ Date: _____

Responsible Party for Payment & Primary Contact Person – <u>your Statement will be mailed to this address:</u>
The Responsible Party must be someone other than the resident. Please do not use facility address.

Name: _____ Phone: _____ (Home/Cell) Email: _____
Circle

Address: _____
(Street) (City) (State / zip)

Additional Person Responsible for Payment–

Name: _____ Phone: _____ (Home/Cell) Email: _____
Circle

Address: _____
(Street) (City) (State / zip)

A valid credit card is required to secure this account – kept on file

Type of card (circle): **Visa / MasterCard / AMX / Discover** **OR** Banking information:

Name on Card: _____ Bank Name _____

Billing Address: _____ Routing Number _____

Card # _____ Bank Account Number _____

Expiration / Security Code _____

☐ **I wish to pay automatically by credit card each month**

☐ **I will mail in payment by check promptly after receipt of Guardian's statement. I understand my credit card will only be used after Guardian notifies responsible party about non-payment of an outstanding balance.**

I wish to pay automatically by credit card each month. I authorize **Guardian Pharmacy** to charge my credit card for the balance of charges not paid by my insurance company. Guardian Pharmacy will charge the balance due about 10 days after statements have been mailed to allow time to review the statement and communicate any issues/concerns.

Accepted by Mary Crowe, <u>President,</u> Guardian Pharmacy of SWFL