



AGREEMENT FOR PHARMACEUTICAL SERVICES

Fax to: (251) 625-6502 OR (866) 478-7909
Attn: Admissions & Billing Departments

Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Rx Advantage, Inc. has contracted with this facility to provide pharmaceuticals, drugs, and/or medical supplies on a 24-hour basis, and in accordance with all State and Federal regulations. Under these requirements, each resident has the right to purchase pharmaceuticals and medications, and to rent or purchase medical supplies and equipment, from the provider of his choice.

Authorization to Bill Third Party

MEDICAL INFORMATION AUTHORIZATION: I hereby authorize my hospital/physician to furnish an agent of Rx Advantage, Inc. with any and all records pertaining to my medical history, services rendered, or treatment.

ASSIGNMENT OF MEDICARE, MEDICAID, OR OTHER INSURANCE BENEFITS: I authorize direct payment to Rx Advantage, Inc. of any insurance benefits for products or services rendered by Rx Advantage, Inc. I also authorize any insurance company (ies) to furnish to an agent of Rx Advantage, Inc. any and all information pertaining to my insurance benefits and status of claims submitted by Rx Advantage, Inc. for services rendered. All forms of insurance must be provided at initiation of service, if not then the responsible party assumes full responsibility of payment for all services rendered by Rx Advantage, Inc. and filing for any reimbursement claims from the insurance company. Rx Advantage, Inc. will provide a printed statement for filing with insurance for reimbursement upon request.

Name of Insurance Company (Include Copy of Card-Front & Back): \_\_\_\_\_ ID #: \_\_\_\_\_
GRP# \_\_\_\_\_

Please Indicate Desired Service by Initialing

\_\_\_\_\_ Yes - I choose to use Rx Advantage, Inc. for all pharmaceuticals, medications, medical supplies and/or equipment, referred herein as supplies, including nutrition supplied by tube feeding.

A. TERMS OF AGREEMENT AND MEDICAL CONSENT: I understand that by signing this agreement, I authorize Rx Advantage, Inc. to provide products or services to me. I also understand that I am under the supervision of my attending physician and Rx Advantage, Inc. is not liable for any act or omission when following the instruction of said physician.

B. ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY: I recognize that all products provided to me by Rx Advantage, Inc. may not be covered, or that reimbursement may be less than 100 percent of charges billed, in accordance with my insurance policy coverage. Therefore, I acknowledge financial responsibility for any balance unpaid by a third-payer, owing on my account. In the event such balance is not paid in full within 30 days of statement, I understand that a past due interest fee will be enforced (Fee limited by Florida State Law). Accounts over 90 days are sent to collections and services are stopped.

C. PAYMENT OPTIONS: Rx Advantage, Inc. accepts personal checks, credit cards (Visa, MasterCard, and Discover) and offers Preauthorized ACH Debit service for your convenience. A separate form must be completed for credit card and ACH Debit service options.

\_\_\_\_\_ No - I choose to use another pharmacy provider. I understand this provider must comply with all applicable federal, state, and local laws and regulations pertaining to providing medications to a resident of a long term care facility. This provider must have the capabilities of providing 24-hour and emergency service.

\_\_\_\_\_ EMERGENCY PROVIDER - I choose to use another pharmacy provider as my primary provider, but I authorize Rx Advantage, Inc. to provide products or services to me in the event that my primary provider can not provide services in a timely manner as determined by the facility. I understand by choosing Rx Advantage, Inc. as an emergency provider I agree with all terms and conditions listed above. There will be a \$25 Administrative fee plus cost of delivery.

Resident/Responsible Party Information (Please Print)

Resident's Name (Printed): \_\_\_\_\_

Resident's SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_
Please Include a Copy of the Power of Attorney if applicable

Responsible Party's Phone Number (Day): \_\_\_\_\_ Alternate Phone Number(s): \_\_\_\_\_

Responsible Party's SSN: \_\_\_\_\_ Responsible Party's Agent's E-Mail: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

X \_\_\_\_\_
Signature of Resident

X \_\_\_\_\_
Signature of Resident's Responsible Party

\* If unable to incorporate a signature, please state reason: \_\_\_\_\_

7101 Highway 90, Suite 300 • Daphne, Alabama 36526
Phone (251) 625-6100 • Toll Free (877) 770-7923 • Fax (251) 625-6502 • Toll Free Fax (866) 478-7909

This facsimile transmission is intended for the individual or company to whom it is addressed and may contain information which is privileged, confidential, and prohibited from disclosure or unauthorized use under applicable law. If the recipient of this transmission is not the intended recipient, or the employee or agent responsible for delivering such materials to the intended recipient, you are hereby notified that any use, discussion, or copying of such material is strictly prohibited by the sender. If you have received this transmission in error, please notify us immediately by telephone at the number above and return the material to the sender by mail. Thank you.