Korman HEALTHCARE

Pharmacy Services, Health Information and Payment Agreement

Patient/Resident Name:	Patient/Resident DOB:	Patient/Resident Room Number:
Patient/Resident Allergies:	Patient/Resident SS#:	
Community Name:	Community Address:	
Community Phone Number:	Community Fax Number:	

The terms "Patient/Resident," "Responsible Party," and "I" mean the individual for whom medications or OTCs have been ordered and, if applicable, his or her representative who has a valid Durable Power of Attorney ("POA") granting the authority to enter into this Agreement and take on financial obligations on the Patient/Resident's behalf. If a POA applies, a copy of the POA must be provided.

Third Party Insurance Information

Patient/Resident is responsible to ensure Pharmacy has a copy of current insurance card (front and back) for billing purposes, and will ensure Pharmacy is notified in advance of any change to the insurance plan or carrier. Patient/Resident understands that failure to notify Pharmacy of changes in insurance may result in otherwise avoidable out of pocket costs to Patient/Resident.

Insurance #1 I.D. #: (Prescription Benefits)	Insurance #2 I.D. #: (Prescription Benefits)
Insurance # 1 Group #	Insurance #2 Group #
Prescription BIN #:	Prescription BIN #:
Insurance # 1 Member Services Phone #:	Insurance #2 Member Services Phone #:
Primary Care Physician	Physician phone: Fax:

Payment Terms

In consideration for the Pharmacy to provide medications and supplies to Patient/Resident on an open account, Patient/Resident does hereby unconditionally guarantee payment to the Pharmacy for all medications and supplies purchased for and supplied to the above-named Patient/Resident. **Per Arizona State law, dispensed medications (including OTC's) are not returnable.** Patient/Resident agrees that all invoices for medications and supplies purchased for and supplied to Patient/Resident are due and payable upon receipt. If an invoice is not paid within 30 days of the invoice date, the amounts owed shall become delinquent and a 1.5% finance charge (18% per annum) will be assessed on the delinquent amount. Patient/Resident is also responsible for attorneys' fees and court costs incurred in the collection of delinquent amounts.

Patient/Resident authorizes the Pharmacy to request on Patient/Resident's behalf all public and private insurance benefits for products/services supplied to Patient/Resident by the Pharmacy, and further authorizes payment for such products/services to be made directly to the Pharmacy.

CHILD SAFETY WAIVER: YOU AGREE AND REQUEST TO WAIVE THE CHILD-RESISTANT SAFETY CAP REQUIREMENT FOR ALL NEW PRESCRIPTIONS AND REFILLS. BUBBLE PACK, BINGO CARDS, PARATA PACKAGED ITEMS ARE NOT CHILD SAFE AND SHOULD BE KEPT OUT THE REACH OF CHILDREN AT ALL TIMES.

Initial: ____________

Election for Non-covered Items
Our dedicated staff works diligently to provide services in a timely manner in spite of the often complex issues related to insurance coverage. Even with our best efforts there may be times when your insurance will not cover all charges, resulting in out of pocket costs to you.

In order to protect you from incurring charges without your approval:
Please select either Option 1 or Option 2 below.

Option 1

I DO NOT authorize Korman Healthcare to dispense over the counter (OTC) and prescription medications and products not reimbursed by my insurance. I am responsible to coordinate these needs directly.

Initial here: ____________

Option 2

I DO authorize Korman Healthcare to dispense over the counter (OTC) and prescription medications and products not fully or partially reimbursed by my insurance. I agree to pay any copay, deductible, or coinsurance amounts owed and to reimburse Korman Healthcare's charges for these items in accordance with the terms of this Agreement, health plan rules, and the Korman Healthcare 3rd Party Billing Authorization/Insurance Agreement.

I also acknowledge that per Arizona law, medications (including OTCs) are NOT returnable.

Initial here: ____________

A Durable Power of Attorney must accompany this form if not signed by Cardholder.
I authorize Korman Healthcare to process my credit card for all Pharmacy purchases, and mail receipts to:

Responsible Party Name and relationship to Patient/Resident:		Responsible Party Address:	
Card Type (Circle One): VISA MASTERCARD DISCOVER		Responsible Party City, State and Zip	
Responsible Party Signature:	Date	CARD #:	EXP. DATE:
Responsible Party Phone Number		Responsible Party Cell Phone Number	

Text Message Program Opt-In
I authorize Korman Healthcare and our affiliates, partners, and independent contractors to send text messages to the responsible party's cell phone number for the purposes of treatment, payment, and health care operations. For more information about our text message program, see our attached Notice of Privacy Practices and our terms and conditions at: https://kormanhealthcare.com/privacy-and-security/. **Y** **N**

I (Patient/Resident) DO NOT select Korman Healthcare as my preferred pharmacy and accept no responsibility for charges that I have not explicitly approved in advance.

Initial: ____________

Agreement not valid unless signed

Patient/Resident/Power of Attorney Signature:	Date	Patient/Resident/Power of Attorney (Print):