Pharmacy Services and Health Information Agreement

Community Name: **Resident Room #**	Allergies:
Community Address:	Patient/Resident SS#:
Patient/Resident Name:	Patient/Resident DOB:

Korman Healthcare (Organization) is committed to support and protect your fundamental human, civil and legal rights and will strive to ensure care is provided in a manner that will preserve these rights. We recognize the unique and individual needs of each person. We strive to extend the highest level of respect and caring to our customers and families. Our customers/families are part of our health care team. The health care team consists of you, your family, your physician, nurses, pharmacists and other providers involved in your care. As a member of the team you have the responsibility to provide complete and accurate information, including present complaints, previous illnesses, hospitalizations, medications, complications or side effects, ask questions about your care/service, follow instructions pertinent to your care, follow the organization's policies and procedures on resident conduct, show respect and consideration of the organization's staff, pay for any care, services and products which are not covered by your insurance when you are billed, and meet financial commitments agreed to with the organization. Please understand Korman Healthcare services are limited to safe and effective medication use. All other aspects of your safety and wellbeing remain the responsibility of the facility/community/home where you reside.

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 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 agreement of the Pharmacy to provide medications and supplies on an open account, Patient/Resident does hereby unconditionally guarantee payment to the Pharmacy for all medications and supplies purchased from the same and supplied to the above-named Patient/Resident.

Per Arizona State law, dispensed medications (including OTC's) are not returnable.

Patient/Resident understands that all bills are due upon receipt. If not paid within 30 days of billing date, a 1.5% finance charge (18% per annum) will be assessed. Patient/Resident also agrees to pay any legal fees and court costs incurred in the collection of this account.

Patient/Resident authorizes any holder of medical and/or insurance information to disclose such information to the Pharmacy. Patient/Resident authorizes the Pharmacy to request on Patient/Resident 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.

Resident Election for Non-covered Items

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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 with the community.

Initial here: _____

Option 2

I DO authorize Korman Healthcare to dispense over the counter (OTC) and prescription medications and products not reimbursed by my insurance. I agree to reimburse Korman Healthcare's charges for these items in accordance with the terms of the Korman Healthcare 3rd Party Billing Authorization/Insurance Agreement.
I acknowledge that per Arizona law, medications (including OTCs) are NOT returnable.

Initial here: _____

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:		Responsible Party Address:	
Card Type (Check One): ◯ VISA ◯ MASTERCARD ◯ DISCOVER		Responsible Party City, State and Zip	
Responsible Party Signature:	Date	CARD #:	EXP. DATE:
Responsible Party Phone Number		Permission to send text messages to responsible party (phone carrier charges may apply). (Check Yes or No)	◯Y ◯N

CHILD SATETY WAIVER: YOU AGREE TO WAIVE THE CHILD-RESISTANT SAFETY CAP REQUIREMENT FOR ALL NEW PRESCDRIPTIONS AND REFILLS. BUBBLE PACK/BINGO CARDS/PRATA ARE NOT CHILD SAFE AND SHOULD BE KEPT OUT THE REACH OF CHILDREN AT ALL TIMES.

Initial: _____

Patient Health Information

Patient/Resident further authorizes the Pharmacy to have access to and disclose any medical and/or insurance information in its possession: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payor who may be responsible for payment of Pharmacy services.

I (Patient/Resident) DO NOT select Korman Healthcare as my preferred pharmacy and accept no responsibility for charges which 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):