Brisma Pharmacy Pllc

RESIDENT/RESPONSIBLE PARTY AGREEMENT

INFORMATION

NAME OF RESIDENT_____SSN_____ ☐ M ☐ F DOB_____

FACILITY NAME_____

NAME OF PERSON TO BE BILLED/POA_____

ADDRESS OF PERSON TO BE BILLED/POA_____

CITY_____STATE_____ZIP_____

HOME PHONE_____ OTHER PHONE_____

RELATIONSHIP TO RESIDENT_____

PAYMENT / INSURANCE INFORMATION

☐ PRIVATE PAY ☐ PRIVATE 3RD PARTY INSURANCE ☐ MEDICAID ☐ OTHER

INSURANCE NAME_____ POLICY NUMBER _____

(COMPANY NAME) (ATTACH COPY OF FRONT AND BACK OF INS CARD)

PHARMACY BENEFIT ☐ YES ☐ NO

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree to use BRISMA PHARMACY for all my prescriptions and pharmaceutical needs.
- I agree that facility personnel are authorized to order purchases and charges on behalf of the above-named resident.
- I agree to pay all charges incurred by the above-named resident that are not paid for by third party payors, including Medicaid, and additional charges for specially packaged medications.
- I will pay the entire amount due within 30 days of the statement date shown on the monthly billing statement and understand that a 1.5% late charge will be added to the balance owed for delinquency of 30 days or more.
- I agree that in order for the resident's account to remain active, payment for billed charges must be made promptly pursuant to these terms.
- I authorize the use of any credit card(s) that I may provide to cover any pharmaceutical or incontinence needs.
- I agree to pay all costs of collection, including court costs and attorney's fees, for all delinquent balances.
- I understand that the medications furnished to the above-named resident are not packaged in child-proof containers.

I consent to the release of personal and medical information to any third party payor, governmental agency providing benefits, or other person/entity liable for my treatment charges. In addition, I consent to a similar release of information, as shall be necessary, to initiate and continue my use of pharmacy, laboratory, or other community resources, and/or for transfer to another health care facility.

_____ _____

(Resident or Responsible Party) (Date)