Apothecare
720 Centre Street, Brockton, MA 02302

RESIDENT AGREEMENT

Resident's Name: _____

Indication of Medical Responsibility
I understand that the Resident is under the supervision and control of his/her attending physician. I understand also that his/her physician has prescribed the therapy/prescriptions as part of the resident's treatment. I understand that Apothecare Pharmacy, LLC does not include diagnosis, prescriptive or other functions typically performed by licensed physicians and that the Resident's condition and otherwise supervising and controlling the Resident's medical care.

Agreement to Pay
Our billing ends on the last day of the month. You will receive a statement around the 5th of the month. This statement will include a copy of your credit card receipt. If there is a change in payor source (i.e., a change to which credit card you would like to use or a change in your insurance coverage), please notify our Accounts Receivable Department at (508) 588-6800. Please feel free to call our Accounts Receivable Department if you have any questions.

Assignment of Benefits
I authorize the release of any medical/other information necessary to process claims. I also authorize payment of medical benefits to be made directly to the Apothecare Pharmacy, LLC for services provided to the above stated Resident.

Release of Information
The undersigned authorizes the insurer(s) and any other third party payor who provides Resident with coverage to disclose to the Apothecare Pharmacy, LLC any information regarding such coverage including but not limited to: (a) payment made by such insurer(s) or third party payor(s) to any of us, for therapy rendered to the Resident by Apothecare Pharmacy, LLC; and (b) the scope and extent of coverage available from time to time. Resident authorizes all medical personnel to provide information the Apothecare Pharmacy, LLC concerning his/her medical history as it may relate to Resident's therapy.

The undersigned consents to the review of his/her records including medical records by and federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

The undersigned certifies that he/she has read the foregoing and received a copy as well as a copy of the Residents Rights and Responsibilities. The undersigned also certifies that he/she is the Resident or is authorized by the Resident as the Resident's general agent to execute the above and accept its terms. NOTE: A duplicate copy of the Agreement and Consent shall be considered the same as an original.
I have received a copy of Apothecare Pharmacy's Privacy Notice.

Resident signature: _____Date:_____

*Spouse/Guarantor/Guardian signature:*_____Date:_____

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Patient name: _____ **Date of Birth:** _____ **Social Security#**_____
Facility Name: _____ **Height:** _____ **Weight:** _____
Street Address: _____ **City:**_____ **State:** _____ **Zip Code:** _____
Do you have any allergies: ☐ **Yes** ☐ **No** **If yes, please state what you are allergic to:**_____

Prescription Insurance/Discount Card:_____**(please attach copy, front & back, if possible)**
Cardholder Name:_____
Relationship to Cardholder: ☐**Self** ☐**Spouse** ☐**Child** ☐**Other**
ID#_____**Group#**_____
BIN _____ **PCN** _____
Insurance Company's Phone Number: _____

Medicare #_____**Medicare Supplement Carrier:** _____
ID#_____ **Group#**_____
Insurance Company's Phone Number: _____
Insurance Company's Address: _____

Physician's Name: _____ **Phone #**_____
Physician's Address: _____
Previous Pharmacy Used: _____ **Phone #**_____

Send statements to Mr./Mrs./Ms:_____ **Relationship to Patient:** _____
Street: _____**Town:**_____
State: _____ **Zip:** _____ **Phone #:**_____
Email address: _____
Emergency Contact: _____ **Relationship:** _____
Phone#:_____

I Authorize Apothecare Pharmacy, LLC to keep my signature on file and to charge my Visa/MasterCard/ Discover account for monthly medication statement charges. I understand that this for is valid through the expiration date of the card unless I cancel the authorization through written notice to Apothecare Pharmacy.
☐**Visa** ☐**MasterCard** ☐**Discover Card**

CreditCard # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration Date: Month_____**Year**_____**Three digit code on back of card**_____
Cardholder (print) (as it appears on card):_____
Cardholder Signature: _____
Cardholder's Address: _____
City: _____ **State:** _____ **Zip:** _____

An itemized statement will be sent to you every month of you purchases along with a copy of your credit card receipt. If you have any questions please call Meaghan McCarthy at (508)588-6800 x 215
PLEASE READ AND SIGN: I understand that by signing this agreement, I indicate my wish to purchase medications and health care products/services from Apothecare Pharmacy, LLC. I (Resident), or my guarantor (if any), agree to personally responsible for the charges of any medications and health care products/services provided by Apothecare Pharmacy, LLC to Resident. This guarantee shall be continuing and unconditional unless canceled by guarantor by written notice to Apothecare Pharmacy, LLC, 720 Centre Street, Brockton, MA 02302.

_____	_____	_____	_____
Date of Agreement	**Client Signature**	**Guarantor Signature**	**Relationship**

Medication List (please provide written prescriptions or request MD to send to pharmacy)

Medication	Dose	Directions	Time of Doses