Medical Arts
Long Term Care Pharmacy

1580 N. Fiesta Blvd. Suite 103
Gilbert, AZ 85233
Phone: 480-253-3100
Fax: 480-497-DRUG (3784)
Toll Free: 866-806-8754

Resident Service Agreement

Date: _____ Resident's Name: _____

I _____ (Responsible Party) authorize Medical Arts LTC Pharmacy to supply medications and supplies ordered by the Community where the Resident resides. I understand that I will be responsible for all payments and / or co-payments not covered by my insurance.

Please initial each paragraph

_____ I have provided Medical Arts LTC Pharmacy with all current and correct insurance and billing information. I will notify Medical Arts LTC Pharmacy of any changes in insurance within five (5) business days. Failure to do so will prevent Medical Arts Pharmacy from billing the appropriate insurance company, and I will be responsible for payment of medications provided.

_____ I understand if a medication is not on the insurance formulary, Medical Arts LTC Pharmacy may contact the prescribing physician to ask for an authorization or medication change. If the physician has not responded within 3 business days, the prescribed medication will be processed and delivered unless Medical Arts LTC Pharmacy is notified by the Responsible Party that they will not be responsible for the charges.

_____ Medication that is delivered to the Community and subsequently discontinued or modified by the Resident's physician or otherwise not used by the Resident for any reason cannot be returned for credit.

_____ The Health Insurance Portability and Accountability Act of 1996 (HIPAA and CMS requires all accredited pharmacies to issue its patients a privacy practice notice as well as Medicare specific documents including Supplier Standards, Patient Bill of Rights and Pharmacy Standards of Service. By signing, you acknowledge receipt of these documents.

_____ (Optional) I authorize Medical Arts LTC Pharmacy to bill my credit card listed below. Medical Arts LTC Pharmacy will send me a copy of the original invoice and payment receipt by the 15th of each month.

_____ I have read this document and understand all liabilities and responsibilities and agree to its terms.

_____ SS# _____-_____-_____

Signature of Responsible Party

Responsible Party Address:_____

_____

(City) (State) (Zip Code)

_____

(Home Phone) (Work Phone) (Mobile Phone)

CC # _____ Exp Date: _____