RESIDENT WELCOME INFORMATION

Welcome to Guardian Pharmacy of Maine! Thank you for choosing us as the pharmacy service provider for you or your loved one.

CONTENTS

We have indicated which documents in the enclosed Welcome Packet need to be signed by the resident and/or responsible party and returned to Guardian.

COPY & SEND Resident Information
Prescription Insurance Card(s)

SIGN & RETURN Pharmaceuticals Purchase Agreement

SIGN & RETURN Assignment of Benefits

If you have any questions, please feel free to contact a Guardian Pharmacy of Maine representative at **(207) 373-9077**.

Thank you for choosing Guardian, our team appreciates your business!

Sincerely,

Courtney Doherty Oland R.Ph., MBA
President, Guardian Pharmacy of Maine
3 Business Parkway, Suite 2
Brunswick, Maine 04011
207-373-9077 ext. 2207
Courtney.oland@guardianpharmacy.net

RESIDENT INFORMATION

Guardian Pharmacy of Maine
3 Business Parkway • Suite 2 • Brunswick ME, 04011 • 207-373-9077 • Fax 207-373-9088

Resident's name: _____
(First) (Middle Initial) (Last)

Birth date: ____/____/____ Social Security # _____ ☐ Male ☐ Female

Community: _____ Apt# _____

Primary Care Physician: _____ Phone #: _____

Medical Diagnosis: _____

Allergies: _____

Prescription Drug Insurance

It is very important for you to provide Guardian Pharmacy of Maine with the latest **prescription insurance** information to enable accurate billing. Most prescription insurance cards have the following information listed below:

Rx Group
Rx BIN Rx PCN Cardholder ID

Prescription Insurance Card: ☐ Yes ☐ No

You MUST complete below information in order for Guardian to file your insurance claims.

Prescription Insurance Plan: _____ Cardholder ID# _____

Rx Group#: _____ Rx BIN#: _____

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other _____

You MUST provide a copy of FRONT and BACK of the following three items or we will not be able to process your insurance:

☐ Prescription insurance card (Front and Back copied)

☐ Medicare Card (includes Medicare Part B or Parts A & B)

_____ _____
(Name of person completing form) (Relationship to Resident)

PHARMACEUTICALS PURCHASE AGREEMENT

Guardian Pharmacy of Maine

3 Business Parkway • Suite 2 • Brunswick ME • 207-373-9077 • Fax 207-373-9088

This is an agreement for pharmacy services with Guardian Pharmacy of Maine

_____ and _____

(Resident) (Responsible Party other than resident)

I agree to pay for any purchases made. I agree to pay the entire amount due within 30 days of the statement date. I authorize facility personnel to make purchases on this account on behalf of the named resident. For Mail-Order repackaged medications, a repacking fee per medication per month will be billed to your account. I understand that finance charges of 1.5% per month may be charged on all past due balances over 30 days. I understand that the use of Guardian Pharmacy of Maine as a provider of pharmaceuticals and other necessities is optional. Guardian Pharmacy of Maine reserves the right to withhold services if payment is 30 days or more past due and no good faith effort has been made to get the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

http://guardianpharmacymaine.com/files/2017/09/Notice-of-Privacy-Practices.pdf

☐ **I certify that I have had an opportunity to review Guardian's Privacy Notice at the above listed internet link and ask questions to assist me in understanding the rights relative to the protection of the above-named person's health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.**

Signed Responsible Party: _____ Date: _____

Responsible Party for Payment & Primary Contact Person: **Your statement will be mailed to this address:**

Name: _____ Phone: _____ (Home/Cell) (Circle)

Email: _____

Address: _____ (City) _____ (State / zip) _____

Alternate Responsible Party:

Name: _____ Phone: _____ (Home/Cell) (Circle)

Email: _____

Address: _____ (City) _____ (State / zip) _____

A valid credit card is recommended to secure this account – kept on file

Type of card (circle): **Visa / MasterCard / American Express / Discover**

Name on Card: _____ **Billing Address**: _____

_____

Card # _____ **Expiration Date** _____ **Security Code*** _____

*** VISA/MC/Discover**: 3-digits on back of card
*** Amex**: 4-digits on front of card

☐ **I wish to pay automatically by credit card each month.** I authorize **Guardian Pharmacy** to charge my credit card, on or around the 20th of the month, for the balance of charges not paid by my insurance company.

☐ I will mail in payment by check promptly after receipt of Guardian Pharmacy's statement. I understand my credit card will only be used after Guardian Pharmacy notifies responsible party about non-payment of an outstanding balance.

As a patient of Guardian Pharmacy of Maine, you acknowledge that you understand the following:

Beneficiary Name (Printed): _____

Date of Birth: _____/_____/_____ Social Security #: _____
Month Day Year

AUTHORIZATION ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize **Guardian Pharmacy of Maine** to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to **Guardian Pharmacy of Maine**. I hereby authorize **Guardian Pharmacy of Maine** to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances. I agree that Guardian Pharmacy of Maine may contact me in the future, via telephone or other means of communication, regarding ordering medical supplies.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Guardian Pharmacy of Maine** for prescription medications or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the HCFA-1500 claim form, or elsewhere on the approved claim form or
electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

_____ _____
Beneficiary or Responsible Party Signature Date

_____ _____
Responsible Party Printed Name (if Beneficiary Unable to Sign) Relationship to Beneficiary

This form kept in Patient Record