# Saliba's
Extended Care Pharmacy
*A Guardian Pharmacy®*

Dear Resident and Family,

**A warm welcome to your new community!**

We understand the care you've taken to find the right community to call home. Selecting the best pharmacy to serve you is just as important. That's why we are delighted to share that your community has chosen to partner with our pharmacy.

We take great pride in this partnership and are committed to ensuring that you get the medications you need, when you need them, safely – and at the right price.

Our professional and compassionate pharmacy team is wholly focused on delivering exceptional care to you and your community's staff. Our services are provided locally, and are designed to make sure you never have to worry about your medication needs.

## Friendly, Knowledgeable Billing Specialists

- **Cost Management** - We coordinate directly with your physicians and insurance company to ensure minimal out-of-pocket medication costs. Unlike a retail pharmacy, we bill medications monthly, and our local billing staff is always ready to answer your billing-related questions.
- **Medicare Benefits Review** - We help you understand your Medicare benefits and offer consultations to help you select a plan that best fits your needs, often saving you money.

## Experienced Senior Care Pharmacists

- **Medication Reviews** - Our pharmacists perform ongoing medication reviews to ensure your medication combinations are safe and appropriate for you.
- **Expert Clinical Care** - They also provide expert clinical support to your community's staff and are always available to answer your medication-related questions.

We are very excited for the opportunity to serve you. If you have any questions, please contact us at 520-818-2883.

Sincerely,

John Saliba

President, Saliba's Extended Care Pharmacy

## WHY USE SALIBA'S?

Our pharmacy is different. As a specialty long-term care (LTC) pharmacy, we are entirely focused on serving communities like yours.

### COMPLIANCE PACKAGING

Easy-to-use packaging options, required by your community, organize your medications by day and time, minimizing the risk of error.

### TIMELY DELIVERIES

Scheduled and emergency deliveries to your community 24/7/365, saving you time and eliminating trips to the local pharmacy.

### INTEGRATED TECHNOLOGY

Our pharmacy system is connected to your community's electronic medication administration record (eMAR), ensuring medication safety and accuracy.

### SCAN TO LEARN MORE

Saliba's Extended Care Pharmacy - Tucson
Phone: (520) 818-2883
Fax: (520) 818-6546

# PHARMACY SERVICES & PURCHASE AGREEMENT

between Guardian Pharmacy of Tucson, LLC and _____
(Full Resident Name)

## Resident Information & Prescription Drug Insurance

Social Security Number _____ Date of Birth ___/___/___ Medicare ID# _____

Community/Facility Name & Address _____ Apt./Room# _____

Primary Care Physician _____ Physician Phone _____

Resident Gender ☐ Male ☐ Female Eligible for VA health care benefits? ☐ Yes ☐ No

Allergies? ☐ Yes ☐ No If yes, please list here _____

**Primary Insurance Information**

Prescription Insurance Plan _____ Cardholder ID# _____ RX Group# _____

RX BIN# _____ PCN# _____ Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other

*A photocopy of the insurance card (front and back) must be included for the pharmacy to process insurance.*

**Additional Insurance? Please provide information here.**

Prescription Insurance Plan _____ Cardholder ID# _____ RX Group# _____

RX BIN# _____ PCN# _____ Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other

## Contact Information

**Primary Contact/Responsible Party** (Statement will be mailed to this contact)

Full Name _____ Phone _____ Email _____

Address _____ Relationship to Resident _____
(Street) (City) (State) (Zip)

**Secondary/Additional Contact**

Name _____ Phone _____ Email _____

Address _____ Relationship to Resident _____
(Street) (City) (State) (Zip)

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## Please review the following statements.

- The Resident/Responsible Party agrees to pay for any purchases made from Guardian Pharmacy, either directly or by facility personnel on the Resident's behalf, and agrees to pay the full invoice amount by the invoice due date.
- Resident/Responsible Party agrees that Guardian Pharmacy will bill the credit card or banking information listed below if payment is not received by the invoice due date.
- Resident/Responsible Party understands and agrees that Guardian Pharmacy will discontinue service if payment is past due and may send to collections and/or report to credit reporting agencies. A finance charge of 1.5% per month may be charged on balances over 30 days past due.
- Some commercial insurance plans do not cover Long Term Care (LTC) Services. If your plan does not cover these services, Resident/Responsible Party agrees to pay the fee for LTC services received that may be reflected on your invoice.
- Resident/Responsible Party understands that the use of Guardian Pharmacy as a provider of pharmaceuticals and other related services is optional.
- I consent to allow Guardian Pharmacy, its agents, and assignees to contact me by email, phone, and SMS message communication using any contact information that I have provided to Guardian Pharmacy, the physician or facility, for purposes related to my care including treatment, insurance benefits, payment, collections, or operations.

**Please initial to acknowledge the above _____**

## Notice of Privacy Practices & Patient Bill of Rights

☐ I certify that I have had an opportunity to review Guardian's Privacy Notice at the below 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. **https://guardianpharmacy.com/hipaa-privacy-policy/**

☐ I certify that I have had an opportunity to review Guardian's Patient Bill of Rights at the below 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**.** **https://guardianpharmacy.com/bill-of-patient-rights/**

## Pharmacy Services

Your community has chosen Guardian Pharmacy as its preferred pharmacy because of the outstanding level of care and service we provide to our residents. However, the Centers for Medicare and Medicaid Services (CMS) guarantees a beneficiary his or her right to a choice of pharmacy providers. We sincerely hope you choose Guardian Pharmacy as your provider, but we will honor your choice if you prefer another provider.

☐ I accept the legal terms and conditions and select to "opt-in" and accept the services provided by Guardian Pharmacy.

☐ I do NOT wish to receive medications from Guardian Pharmacy and would like to "opt-out" or decline the services provided by Guardian Pharmacy.

**Print Resident Name _____ Date _____**

**Resident or Responsible Party Signature: _____**

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## Payment Information

**Please select one of the following options.**

- ☐ I wish to pay automatically by credit card each month. Please enroll me in credit card auto-pay.
  *This option requires the Credit Card Information box below (on the right side) to be filled out.*
- ☐ I wish to pay automatically by ACH (bank account) each month. Please enroll me in ACH auto-pay.
  *This option requires the Banking Information box below (on the left side) to be filled out.*
- ☐ I will mail in payment by check each month, pay monthly via online credit card portal, or call to pay by phone each month, promptly after receipt of Guardian's statement.
- ☐ I receive low-income government assistance to help pay for my prescription co-pays.

**Banking Information:**

Bank Name: _____

Bank Routing Number:
☐☐☐☐☐☐☐☐☐

Bank Account Number:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
*(Number of digits varies by banking entity)*

Name on Account: _____

**Credit Card Information:**

Card Type (circle): Visa / MasterCard/ AMEX / Discover

Cardholder Name: _____
Billing Address: _____
_____

☐ Check here if the billing address is same as primary contact above

Card #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration: ☐☐/☐☐ Security Code: ☐☐☐☐

**Print Resident Name** _____ **Date** _____

**Resident or Responsible Party Signature:** _____

**Thank you for choosing Guardian Pharmacy!**

**Learn more at guardianpharmacy.com**