Guardian Pharmacy of Anaheim
184 E Liberty Ave
Anaheim, CA 92801
Phone: (714) 220-0720 | Fax: (714) 461-0138
guardianpharmacyanaheim.com

PHARMACY SERVICES & PURCHASE AGREEMENT

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

Resident Information & Prescription Drug Insurance

Social Security Number_____ Date of Birth____ /_____ /_____ Medicare ID #_____

Community/Facility Name & Address _____

Primary Care Physician_____ Physician Phone_____ □ MALE □ FEMALE

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

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

Address (statement will be mailed to this address): _____
(Street) (City) (State / Zip)

Secondary/Additional Contact

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

Address: _____
(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 Opt-Out

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.

Resident or Responsible Party Signature: _____

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Payment Information

Please fill out one of the boxes below to provide Banking (preferred) or Credit Card information or select the statement below if applicable.

☐ 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: _____

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

Cardholder Name: _____
Billing Address:_____
_____
☐ Check if the billing address is same as primary contact above
Card #:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Expiration: ☐☐/☐☐ Security Code: ☐☐☐☐

Please select one of the following payment options:

☐ I want to enroll in automatic payment processing using the information provided above and I authorize Guardian Pharmacy to collect payment for charges not paid by my insurance company. Automatic payments will be processed based on the invoice due date.

☐ I will manually submit monthly payments by the invoice due date and authorize Guardian Pharmacy to bill the payment method above if payment is not received by the invoice due date.

Resident or Responsible Party Signature: _____

Thank you for choosing to use Guardian Pharmacy!

Learn more at https://guardianpharmacy.com/