Agreement01

Updated April 2023

RESIDENT WELCOME INFORMATION

Welcome to Guardian Pharmacy Atlanta! Your community uses Guardian as their pharmacy provider. We can deliver the best possible service and ensure you get the medications you need, when you need them, safely, and at the right price.

WHY USE GUARDIAN?

- **Cost Management** - Guardian coordinates directly with your physicians and third-party insurance providers to ensure minimal out-of-pocket medication costs
- **Billing Support** - Unlike a retail pharmacy, Guardian bills medications monthly, and their local billing staff is always ready to answer billing-related questions
- **Medicare Guidance** - The pharmacy helps you understand your Medicare Part D coverage and can offer one-on-one consultations during open enrollment
- **Clinical Support** - Guardian conducts ongoing medication reviews to ensure you're on the appropriate drug regimen
- **Compliance Packaging** - Easy-to-use packaging options required by your community, organize your medications, and minimize the risk of error
- **Timely Delivery-** Scheduled and emergency deliveries are available 24/7, eliminating trips to a local retail pharmacy
- **Integrated Technology-** Guardian's seamless integration of our community's electronic medication administration record (eMAR) system eliminates transcription errors and improves medication management

Guardian Pharmacy of Atlanta designs services to make sure you never have to worry about your medication needs. That's why your community has chosen Guardian Pharmacy of Atlanta as their preferred pharmacy provider.

In order to receive service by Guardian Pharmacy of Atlanta, please complete the enclosed paperwork and return it to your community, or you can mail//email/fax to the pharmacy:

Guardian Pharmacy of Atlanta
877 Franklin Gateway
Suite 200
Marietta, GA 30067
Phone: 770-635-3301
Fax: 770-635-3302
Email: Ecmatlanta@guardianpharmacy.net

Thank you,

Matthew Hopp

Matthew Hopp, MBA | President - Guardian Pharmacy of Atlanta
http://www.guardianpharmacyatlanta.com

Agreement01

Updated April 2023

RESIDENT ENROLLMENT FORM

RESIDENT NAME: _____ MOVE IN DATE: ____/____/____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN: _____-_____-_____ DOB: ____/____/____ MEDICARE ID# _____ ☐ MALE ☐ FEMALE

COMMUNITY NAME **(PLEASE ADD FULL NAME)** _____ ROOM#: _____

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN'S PHONE: _____

MEDICAL DIAGNOSIS: _____ ALLERGIES: _____
[PLEASE PROVIDE MEDICAL DX] [PLEASE PROVIDE ALLERGIES]

REPACKED MEDICATION INFORMATION

WILL RESIDENT BE REPACK: ☐ NO ☐ YES

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

☐ NO MEDICATION AT THIS TIME [RESIDENT HAS ENOUGH ON HAND]

☐ GUARDIAN TO SUPPLY ALL MEDICATIONS

☐ PATIENT TO SUPPLY RETAIL PHARMACY MEDICATION (ONE TIME REPACK ONLY)

☐ ONGOING REPACK PATIENT

☐ VA ☐ KAISER ☐ MAIL ORDER

☐ ONLY SEND THE FOLLOWING MEDICATIONS LISTED

_____

PRESCRIPTION DRUG INSURANCE

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**

RESPONSIBLE PARTY INFORMATION

PRIMARY RP: _____ RELATIONSHIP TO PATIENT: _____
[FIRST] [LAST

PHONE: _____-_____-_____ ☐ HOME ☐ CELL EMAIL ADDRESS: _____

ADDRESS: _____
***MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS**

SECONDARY RP:_____ RELATIONSHIP TO PATIENT: _____
[FIRST] [LAST

PHONE: _____-_____-_____ ☐ HOME ☐ CELL EMAIL ADDRESS: _____

ADDRESS: _____
***SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS THEIR OWN PRIMARY CONTACT**

Agreement01

Updated April 2023

RESIDENT ENROLLMENT PAYMENT FORM

A valid credit card or ACH payment method is required to be kept on file to secure this account. Please check one of the boxes below based on your preferred payment method. Failure to provide payment information will inactivate resident's account until received.

ACH / CHECKING ACCOUNT INFORMATION

NAME OF BANK: _____ **NAME ON ACCOUNT:** _____

ROUTING NUMBER: _____ **ACCOUNT NUMBER:** _____

OR

CREDIT CARD INFORMATION

TYPE OF CARD: □ VISA □ MASTERCARD □ AMERICAN EXPRESS □ DISCOVER

NAME ON CARD: _____ **CARD NUMBER:** _____

BILLING ADDRESS: _____ **EXPIRATION (MM/YY)** _____/_____

_____ **SECURITY CODE:** _____

***VISA/MC/DISCOVER: 3 DIGITS ON BACK OF CARD**

***AMEX: 4 DIGITS ON FRONT OF CARD**

PLEASE SELECT AN OPTION BELOW AND SIGN. *If the patient will be their own responsible party, they must select autopay

☐ I wish to pay automatically by credit cord each month - please enroll me in autopay.

☐ I wish to pay automatically by electronic check each month - please enroll me in autopay.

☐ 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. *

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE: _____ Date: _____/_____/_____

Agreement01

Updated April 2023

PHARMACY SERVICES AGREEMENT

Guardian Pharmacy of Atlanta 877 Franklin Gateway Suite 200

Marietta, GA 30067

Phone: 770-635-3301 I Fax: 770-635-3302

This is an agreement for pharmacy services with Guardian Pharmacy of Atlanta and

_____ and _____

[RESIDENT] [RESPONSIBLE PARTY]

In exchange for Guardian Pharmacy's agreement to provide me with medications, I agree to the following terms and conditions:

1.**AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Guardian Pharmacy of Atlanta, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.

2.**MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by Guardian Pharmacy of Atlanta. Guardian Pharmacy of Atlanta does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.

3.**FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, Guardian Pharmacy of Atlanta may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize Guardian Pharmacy of Atlanta to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.

4.**FINANCIAL RESPONSIBILITY**. In consideration of Guardian Pharmacy of Atlanta supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by Guardian Pharmacy of Atlanta. If, for any reason, Guardian Pharmacy of Atlanta does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay Guardian Pharmacy of Atlanta directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account. Some commercial insurance plans do not cover Long Term Care (LTC) Services. If your plan does not cover these services, a fee for LTC services received may be reflected on your statement.

5.**PAYMENT OF BENEFITS**. I authorize Guardian Pharmacy of Atlanta to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to Guardian Pharmacy of Atlanta.

6.**ASSIGNMENT OF BENEFITS**. I authorize Guardian Pharmacy of Atlanta to request and collect on my behalf all public and private benefits due for the products and services supplied by Guardian Pharmacy of Atlanta. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Guardian Pharmacy of Atlanta

7.**UNPAID INVOICES**. Guardian Pharmacy of Atlanta encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by Guardian Pharmacy of Atlanta related to collection efforts, including reasonable attorneys' fees and court costs.

8.**WITHHOLD SERVICES**. Guardian Pharmacy of Atlanta reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.

9.**RELEASE OF INFORMATION**. I authorize any insurer or third-party payor who provides me with coverage to disclose to Guardian Pharmacy of Atlanta any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by Guardian Pharmacy of Atlanta. I also authorize all medical personnel to disclose information to Guardian Pharmacy of Atlanta relating to my medical history as it related to pharmacy services or therapy.

10.**HIPAA AUTHORIZATION**. I give permission to Guardian Pharmacy of Atlanta to use or disclose certain aspects of my health information to the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE: _____ Date: _____/_____/_____

Agreement01

Updated April 2023

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of Guardian Pharmacy of Atlanta privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that Guardian Pharmacy of Atlanta is committed to protecting my health information. I certify that I have read and understand this agreement:

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of Guardian Pharmacy of Atlanta Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify that I have received a copy of Guardian Pharmacy of Atlanta Injury, infection, and emergency preparedness protocol and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

PAYMENT INFORMATION

I certify that I have received a copy of Guardian Pharmacy of Atlanta payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

I UNDERSTAND AND HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES, THE NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES, THE MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS, INJURY, INFECTION AND EMERGENCY PREPAREDNESS, AND THE PAYMENT INFORMATION DOCUMENTS AND AGREE TO BE BOUND BY THEM.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE: _____ Date: _____/_____/_____