Customer Agreement to Pay
(Please attach copy of front and back of insurance card)

Patient/ Resident Name (Please Print): _____

Patient's Date of Birth: _____ Soc. Sec. #: _____

Guardian or Financial POA (If Different from Patient): _____

Relationship to Patient/ Resident: ___ Spouse ___ Child ___ Legal Dependent ___ POA

Each month an itemized bill for pharmacy services not covered by insurance will be sent to you. This bill is payable directly to Guardian Pharmacy of Maine upon receipt. If payment is not received by the next billing cycle, a 1.5% late fee (or a minimum $2.00 charge) will automatically be charged. Guardian Pharmacy of Maine also accepts payment by credit card (If you wish to pay by credit card, complete and return the enclosed Credit Card Authorization Form).

Request for Services

I understand that by signing this agreement I indicate my wish to purchase health care products or services from Guardian Pharmacy of Maine.

Indication of Medical Responsibility

I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed the therapy, equipment and/ or supplies noted as part of my treatment. I understand Guardian Pharmacy of Maine services do not include diagnostic, prescriptive or other functions typically performed a licensed physician and that my physician is solely responsible for diagnosing and prescribing drugs and therapy for my condition, and supervising and controlling my medical care.

Assignment of Benefits

The undersigned hereby authorizes Guardian Pharmacy of Maine to request on my behalf and collect all public and private insurance coverage benefits due for the products and services supplied to the Patient by the Guardian Pharmacy of Maine. In the event payment for insurance benefits is made directly to any of the undersigned, the payee will endorse all checks for such payment to Guardian Pharmacy of Maine.

Release of Information

The Undersigned authorizes the insurer(s) and any other third party payor who provides the Patient with coverage to disclose to the Guardian any information regarding such coverage, including but not limited to:

a. payment made by such insurer(s) or third party payor(s) to any of us, for the therapy rendered to the Patient by Guardian Pharmacy of Maine; and
b. the scope and extent of coverage available from time to time. The Patient authorizes all medical personnel to provide information to Guardian concerning his/ her medical history if it relates to the Patient's therapy.

The undersigned consents to the review of his/ her records including medical records by any federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

Customer Agreement to Pay

In consideration of Guardian Pharmacy of Maine undertaking to supply the Patient with any products and services ordered by the Patient or on behalf of the Patient, the undersigned Patient, spouse, guarantor and/ or guardian agrees that each of them is responsible to Guardian Pharmacy of Maine for payment to Guardian Pharmacy of Maine for all such products and services provided to the Patient, unless they are a Medicare Part B recipient where Guardian Pharmacy of Maine has accepted assignment or a Medicaid recipient. In addition, the Patient agrees to be responsible for the full amount of charges (plus any collection costs), if no payment is made for the claims submitted to the insurance company; or if within forty five (45) days, the Patient's physician or the Patient fail to provide the information necessary to submit the claim for services. I agree to transfer immediately to Guardian Pharmacy of Maine any payment made directly to me for services provided by Guardian Pharmacy of Maine on an assigned basis. If the Patient has MaineCare, the Patient is responsible for any and all co-payments and non-covered items.

Authorized Credit Limit

Authorized Credit Limit: ____ $2,000 or if less than $2000 limit is desired, please enter amount below

____ $_____

The undersigned certifies that he/ she is the Patient, or is authorized by the Patient as the Patient's general agent, to execute the above and accept the terms. **Note**: A duplicate copy of this Agreement and Consent shall be considered the same as the original.

Patient/ Resident Signature: _____ Date: _____

Guardian or POA Signature: _____ Date: _____

Guardian or POA Name (Please Print): _____

Mailing Address: _____
Street

_____ _____ _____
City/ Town State Zipcode

Phone #: _____ ____Home# _____ Work# ____ Cell #

E-Mai Address: _____

Reminder: Please attach a copy of the front and back of your prescription insurance card to this form or telephone us at 1-866-415-1954 and ask to speak with a billing specialist. Thank you.