RESIDENT ENROLLMENT FORM

RESIDENT INFORMATION

RESIDENT NAME _____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# _____-_____-_____ DOB _____/_____/_____ □ MALE □ FEMALE

COMMUNITY NAME _____ APT# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER _____

**A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE*

RESPONSIBLE PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____
[STREET] [CITY] [STATE] [ZIP CODE]

**MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS*

SECONDARY* _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

**SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT*

RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

A valid credit card is required to be kept on file to secure this account.

TYPE OF CARD (circle): VISA MASTERCARD AMERICAN EXPRESS DISCOVER

NAME ON CARD _____ CARD NUMBER _____

BILLING ADDRESS _____ EXPIRATION (MMYY) _____/_____

_____ 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.

☐ *I wish to pay automatically by credit card each month – please enroll me in auto-pay.*

☐ *I will mail in payment by check 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 _____

PHARMACY SERVICES AGREEMENT

Guardian Pharmacy of Kansas City, LLC
15317 West 95th Street
Lenexa, KS 66219

Phone: 866-860-4179
Fax: 866-328-3491
www.guardianpharmacyheartland.com

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

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for Guardian Pharmacy of Kansas City'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 Kansas City, 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 Kansas City. Guardian Pharmacy of Kansas City 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 Kansas City 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 Kansas City 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 Kansas City 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 Kansas City. If, for any reason, Guardian Pharmacy of Kansas City 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 Pharmacy of Kansas City directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account.
5. **PAYMENT OF BENEFITS.** I authorize Guardian Pharmacy of Kansas City 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 Kansas City.
6. **ASSIGNMENT OF BENEFITS.** I authorize Guardian Pharmacy of Kansas City to request and collect on my behalf all public and private benefits due for the products and services supplied by Guardian Pharmacy of Kansas City. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Guardian Pharmacy of Kansas City.
7. **UNPAID INVOICES.** Guardian Pharmacy of Kansas City 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 Kansas City related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Guardian Pharmacy of Kansas City 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 Kansas City 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 Kansas City. I also authorize all medical personnel to disclose information to Guardian Pharmacy of Kansas City relating to my medical history as it related to pharmacy services or therapy.

10. **HIPAA AUTHORIZATION.** I give permission to Guardian Pharmacy of Kansas City 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.

I have read and understand the above terms and conditions and agree to be bound by each of them:

Signature [Resident or Responsible Party]**: _____ Date: _____**

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

I certify that I have received a copy of Guardian Pharmacy of Kansas City's 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 Kansas City is committed to protecting my health information. I certify that I have read and understand this agreement:

_____**Resident or responsible Party Initial**

PAYMENT INFORMATION

I certify that I have received a copy of Guardian Pharmacy of Kansas City's 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.

_____**Resident or responsible Party Initial**

I understand and have reviewed all of the above documents and agree to be bound as applicable.

Signature [Resident or Responsible Party]**: _____ Date: _____**

PAYMENT INFORMATION

Guardian Pharmacy offers three easy and convenient ways to pay your pharmacy bills.

ONLINE BILL PAY

The online portal is flexible, easy to use, and available 24/7. Manage multiple users and accounts, monitor payment activity, view your statements and enroll in electronic statement delivery.

Create an account in our online payment portal to make a one-time payment or set up automatic recurring payments. Recurring payments take the hassle out of remembering to pay your bill by allowing you to choose the date that your monthly payment is processed. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express).

The link to the online portal is paymissouri.guardianpharmacy.net. This can also be found on your monthly statements.

PAY BY PHONE

Use our automated payment system to make a payment by phone using the access code and zip code listed on your statement. Payments can be made via your checking account or credit card (VISA, Mastercard, American Express). Call 877-910-4303. This number can also be found on each monthly statement.

PAY BY MAIL

Mail in a check or money order payment directly to the address listed on your statement to make a payment. If paying by check or money order, please include your name or account number. If I send a non-sufficient funds check, I understand and agree that Guardian Pharmacy of Kansas City may charge a forty ($40) dollar service charge and give you an opportunity to rectify the payment by sending another check without a break in service.

Pharmacy address: Guardian Pharmacy of Kansas City LLC Private Pay
PO Box 2153
Dept. 8384
Birmingham, AL
35287-8384

If you have any questions regarding your bill or how to use one of these payment methods, please reach out to the Guardian Pharmacy of Kansas City billing team for assistance. 1-866-860-4179