720 Centre Street, Brockton, MA 02302

RESIDENT AGREEMENT

Resident's Name: ____

Indication of Medical Responsibility
I understand that the Resident is under the supervision and control of his/her attending physician. I understand also that his/her physician has prescribed the therapy/prescriptions as part of the resident's treatment. I understand that Apothecare Pharmacy, LLC does not include diagnosis, prescriptive or other functions typically performed by licensed physicians and that the Resident's condition and otherwise supervising and controlling the Resident's medical care.

Agreement to Pay
Our billing ends on the last day of the month. You will receive a statement around the 5th of the month. This statement will include a copy of your credit card receipt. If there is a change in payor source (i.e., a change to which credit card you would like to use or a change in your insurance coverage), please notify our Accounts Receivable Department at (508) 588-6800. Please feel free to call our Accounts Receivable Department if you have any questions.

Assignment of Benefits
I authorize the release of any medical/other information necessary to process claims. I also authorize payment of medical benefits to be made directly to the Apothecare Pharmacy, LLC for services provided to the above stated Resident.

Release of Information
The undersigned authorizes the insurer(s) and any other third party payor who provides Resident with coverage to disclose to the Apothecare Pharmacy, LLC 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 therapy rendered to the Resident by Apothecare Pharmacy, LLC; and (b) the scope and extent of coverage available from time to time. Resident authorizes all medical personnel to provide information the Apothecare Pharmacy, LLC concerning his/her medical history as it may relate to Resident's therapy.

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

The undersigned certifies that he/she has read the foregoing and received a copy as well as a copy of the Residents Rights and Responsibilities. The undersigned also certifies that he/she is the Resident or is authorized by the Resident as the Resident's general agent to execute the above and accept its terms. NOTE: A duplicate copy of the Agreement and Consent shall be considered the same as an original.
I have received a copy of Apothecare Pharmacy's Privacy Notice.

Resident signature: ____Date:_______________

*Spouse/Guarantor/Guardian signature:*________________________Date:_______________

Apothecare
720 Centre Street, Brockton, MA 02302

Patient name: ___________________________ Date of Birth: ___________ Social Security#__________________
Facility Name: _______________________ Height: _______ Weight: __________
Street Address: _________________ City:___________ State: _______ Zip Code: ______
Do you have any allergies: ☐ Yes ☐ No If yes, please state what you are allergic to:_______________________

Prescription Insurance/Discount Card:_________________________________(please attach copy, front & back, if possible)
Cardholder Name:____
Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other
ID#______________________Group#______________________________
BIN _____________________ PCN ________________________________
Insurance Company's Phone Number: _______________________________

Medicare #____________________Medicare Supplement Carrier: ____________________________________
ID#______________________ Group#______________________
Insurance Company's Phone Number: _______________________________
Insurance Company's Address: ____

Physician's Name: _______________________________________ Phone #____________________
Physician's Address: ____
Previous Pharmacy Used: _________________________________ Phone #____________________

Send statements to Mr./Mrs./Ms:______________________________ Relationship to Patient: ____________
Street: ____Town:______________________
State: ____________________________ Zip: _____________ Phone #:________________________
Email address: ____
Emergency Contact: _______________________________ Relationship: ______________________
Phone#:______________________________

I Authorize Apothecare Pharmacy, LLC to keep my signature on file and to charge my Visa/MasterCard/ Discover account for monthly medication statement charges. I understand that this for is valid through the expiration date of the card unless I cancel the authorization through written notice to Apothecare Pharmacy.
☐ Visa ☐ MasterCard ☐ Discover Card

CreditCard # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration Date: Month_______Year________Three digit code on back of card_____________
Cardholder (print) (as it appears on card):____
Cardholder Signature: ____
Cardholder's Address: ____
City: _____________________________________ State: _______________ Zip: ______________

An itemized statement will be sent to you every month of you purchases along with a copy of your credit card receipt. If you have any questions please call Meaghan McCarthy at (508)588-6800 x 215
PLEASE READ AND SIGN: I understand that by signing this agreement, I indicate my wish to purchase medications and health care products/services from Apothecare Pharmacy, LLC. I (Resident), or my guarantor (if any), agree to personally responsible for the charges of any medications and health care products/services provided by Apothecare Pharmacy, LLC to Resident. This guarantee shall be continuing and unconditional unless canceled by guarantor by written notice to Apothecare Pharmacy, LLC, 720 Centre Street, Brockton, MA 02302.

______________	______________	______________	______________
Date of Agreement	**Client Signature**	**Guarantor Signature**	**Relationship**

Medication List (please provide written prescriptions or request MD to send to pharmacy)

Medication	Dose	Directions	Time of Doses