Guardian Pharmacy of Birmingham
201 London Parkway, Suite 400 | Birmingham, AL 35211
Ph. (205) 451-1822 | Fax (205) 451-1823
Email: billing.birmingham@guardianpharmacy.net
guardianpharmacybham.com

PHARMACY SERVICES & PURCHASE AGREEMENT

between Guardian Pharmacy of Birmingham, 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

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 for Payment & Primary Contact Person – <u>your Statement will be mailed to this address:</u>

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

Address: _____
(Street) (City) (State / Zip)

Credit Card or Banking Information is required. Please fill out one of the boxes below.

The following information may be provided by completing the form below, receiving a secure link to fill out the form electronically, or contacting the billing department at (205) 451-1829.

Type of Card (circle): Visa / MasterCard/ AMEX / Discover
Cardholder Name: _____
Billing Address:_____
_____
☐ Check if the billing address is same as above
Card #:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Expiration: ☐☐/☐☐ Security Code: ☐☐☐☐

Banking Information:
Bank Name: _____
Bank Routing Number:
☐☐☐☐☐☐☐☐☐
Bank Account Number:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Number of digits varies by banking entity)
Name on Account: _____

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: _____ Date: _____

****DO NOT STORE IN RESIDENT'S CHART****

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Please review the following statements.

- Resident/Responsible Party agrees to pay for any purchases made from Guardian Pharmacy either directly or by facility personnel on Resident's behalf and agree to pay the full invoice amount by invoice due date.
- Resident/Responsible Party agrees that Guardian Pharmacy may bill the credit card or banking information listed above 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.
- Resident/Responsible Party understands and agrees that Guardian Pharmacy may, at the phone number provided above, make automated phone calls and send SMS text messages and other types of automated messages and reminders regarding billing and payment for Guardian Pharmacy's services.

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/

Resident or Responsible Party Signature: _____ Date: _____

****DO NOT STORE IN RESIDENT'S CHART****