RESIDENT WELCOME INFORMATION

Welcome to Guardian Pharmacy! Thank you for choosing us as the pharmacy service provider for you or your loved one.

CONTENTS

We have indicated which documents in the enclosed Welcome Packet need to be signed by the resident and/or responsible party and returned to Guardian.

COPY & SEND Resident Information
Prescription Insurance Card(s)

SIGN & RETURN Pharmaceuticals Purchase Agreement

If you have any questions, please feel free to contact a Guardian Pharmacy Representative at **(954) 601-2121**.

Thank you for choosing Guardian Pharmacy of Southeast Florida, our team appreciates your business!

Sincerely,

Alan Traster R.Ph. C.C.P., F.A.S.C.P.
President
Guardian Pharmacy of Southeast Florida
354 SW 12th Avenue, Bldg.7
Deerfield Beach, FL 33442
Office: 954-601-2121
Fax: 954-601-2400
atraster@grxfl.com

RESIDENT INFORMATION

Guardian Pharmacy of Southeast Florida

354 SW 12th Ave., Bldg.7, Deerfield Beach FL, 33442 Office: 954-601-2121 Fax: 954-601-2400

Resident's name: _____
(First) (Middle Initial) (Last)

Birth date: ____/____/____ Social Security # _____ ☐ Male ☐ Female

Community: _____ Apt# _____

Primary Care Physician: _____ Phone #: _____

Medical Diagnosis: _____

Allergies: _____

Prescription Drug Insurance

It is very important for you to provide Guardian with the latest proper **prescription insurance** information to enable accurate billing. Most prescription insurance cards have the following information listed below:

Rx Group
Rx BIN Rx PCN
Cardholder ID

Prescription Insurance Card: ☐ Yes ☐ No
You MUST complete below information in order for Guardian to file your insurance claims.

Prescription Insurance Plan: _____ Cardholder ID# _____

Rx Group#: _____ Rx BIN#: _____

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other _____

You MUST provide a copy of FRONT and BACK of the following three items or we will not be able to process your insurance:

☐ Prescription insurance card

☐ Medicare Card (includes Medicare Part B or Parts A & B)

☐ Photo ID

_____ _____
(Name of person completing form) (Relationship to Resident)

PHARMACEUTICALS PURCHASE AGREEMENT

Guardian Pharmacy of Southeast Florida

354 SW 12th Ave., Bldg.7, Deerfield Beach FL, 33442 Office: 954-601-2121 Fax: 954-601-2400

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

_____ and _____

(Resident) (Responsible Party other than resident)

I agree to pay for any purchases made. I agree to pay the entire amount due within 15 days of the statement date shown. I authorize facility personnel to make purchases on this account on behalf of the named resident. For Mail Order repackaged medications, a repacking fee per medication per month will be billed to your account. I understand that finance charges of 1.5% per month may be charged on all past due balances over 30 days. I understand that the use of Guardian Pharmacy as a provider of pharmaceuticals and other necessities is optional. Guardian reserves the right to withhold services if payment is 30 days or more past due and no good faith effort has been made to get the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

http://www.guardianpharmse.com/forms-documentation/

☐ **I certify that I have had an opportunity to review Guardian's Privacy Notice at the above 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. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.**

Signed Responsible Party: _____ Date: _____

Responsible Party for Payment & Primary Contact Person – <u>your Statement will be mailed to this address:</u>
The Responsible Party must be someone other than the resident. Please do not use facility address.

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

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

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

Type of card (circle): **Visa / MasterCard / American Express / Discover**

Name on Card: _____ **Billing Address**: _____

Card # _____ **Expiration** _____ **Security Code*** _____

*** VISA/MC/Discover**: 3-digits on back of card
*** Amex**: 4-digits on front of card

☐ **I wish to pay automatically by credit card each month**

☐ I will mail in payment by check promptly after receipt of Guardian's statement. I understand my credit card will only be used after Guardian notifies responsible party about non-payment of an outstanding balance.

I wish to pay automatically by credit card each month. I authorize **Guardian Pharmacy** to charge my credit card for the balance of charges not paid by my insurance company. Guardian will charge the balance due about 10 days after statements have been mailed to allow time to review the statement and communicate any issues/concerns.

Accepted by: Alan Traster, President of Guardian Pharmacy SEFL