Resident Intake and Agreement Form - Hartzell's Pharmacy

Name (Last, First, MI):		Date of Birth:
Gender: □ Male □ Female	Phone:	Social Security Number:
Facility or Community Name *(if applicable)*:		Room Number:
Address:		
City:	State:	Zip Code:
Known Allergies:		
Primary care physician:		

Correspondence, including invoices for payment, for the patient should be sent to (please check appropriate box):

□ **Patient** at the address listed above

□ **Other** please list name, relationship to patient, mailing address, phone number, and email below. Please note they will need to also sign the last page of this document**:**

Access To Records *(optional – complete for those individuals you will allow us to discuss your health with)***:**
I grant Hartzell's Pharmacy permission to share and discuss information concerning my treatment and health, including any Protected Health Information (PHI), with the following individuals (please list name and relationship to patient):

Please include with this form the following documents:

- Copies of all **insurance cards**, including Medicare card if applicable
- Copies of **Social Security card**
- **Presriptions** to be filled at this time

 Resident/Authorized Representative Initials: ______________

Agreement for Services

By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the following terms:

1. **Authorizations:** Hartzell's Pharmacy, Inc. and its subsidiaries ("Hartzell's Pharmacy") are authorized to provide the Patient all products and services prescribed or ordered by the Patient's Physician(s). The Patient requests the products provided by Hartzell's Pharmacy be dispensed in containers that are not child resistant. The patient requests that Hartzell's Pharmacy cycle fill maintenance medications in a **28 or 30 day supply**, depending on facility preference. Cycle fill automates the delivery of the majority of an individual's maintenance medications, greatly reducing the number of reorders that need to occur. Hartzell's Pharmacy may need to cycle up new medications in order to align them with the cycle. The Patient understands this may require filling less than the amount prescribed on the prescription order. The Patient requests that Hartzell's Pharmacy dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to pharmacy policy as allowed by professional standards and federal and/or state regulations.
2. **Legal Representative:** Legal Representatives will provide Hartzell's Pharmacy with documentation establishing their legal authority.
3. **Notice of Privacy Practices:** The Patient or their Legal Representative acknowledge that they have been informed that a copy of Hartzell's Pharmacy's Notice of Privacy Practices is available at www.hartzells.com. The Patient or their Legal Representative may at any time contact Hartzell's Pharmacy directly in order to request a copy of Hartzell's Pharmacy's Notice of Privacy Practices for their records.
4. **Assignment of Benefits:** The Patient or their Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Hartzell's Pharmacy for products and services provided to the Patient.
5. **Billing:** The Resident or their Financially Responsible Party acknowledges that Hartzell's Pharmacy will bill the Resident or their Financially Responsible Party directly for the provision of all products and services monthly. Charges from Hartzell's Pharmacy are not part of any billing received from the facility in which they reside.
6. **Payment:** The Resident or their Financially Responsible Party is responsible for paying all charges for products and services provided to the Resident by Hartzell's Pharmacy. As a courtesy, Hartzell's Pharmacy will submit claims on behalf of the Resident to all insurance companies or other third-party payers we have signed contractual obligations, however the Resident and the Financially Responsible Party are ultimately responsible for paying any charges not covered by insurance or another third party payer. Payment in full is due within thirty (30) days of the statement date, and a late fee of $15 will accrue on all delinquent accounts beginning on the day after the payment is due. The Resident or their Legal Representative and/or Financially Responsible Party hereby authorize Hartzell's Pharmacy to charge any credit card or bank account number identified above for any amounts owed.
7. **Fees and Expenses:** The Resident and their Financially Responsible Party are responsible for paying all costs and expenses incurred by Hartzell's Pharmacy in the collection of amounts owed and the enforcement of its rights under this agreement, including without limitation, attorney's fees, collection fees, court costs and expenses.
8. **Assurance of Payment and Termination of Services:** The Resident or Legal Responsible and Financially Responsible Party acknowledge that if the Resident and Financially Responsible Party are delinquent on payment of any amount owed to Hartzell's Pharmacy, Hartzell's Pharmacy may, in its sole discretion, do either or both of the following:
    a. Condition its continued provision of products and services to the Resident upon Hartzell's Pharmacy's receipt of assurance of payment acceptable to Hartzell's

 Resident/Authorized Representative Initials: _______________

Pharmacy, which may include, without limitation, a requirement that Hartzell's Pharmacy receive authorization to charge all amount owed, past and future, to a valid credit card number; and/or

b. Suspend or terminate its provision of products and services to the Resident. Such suspension or termination will in no way affect the Resident's or Financially Responsible Party's obligation to pay all amounts owed under this agreement, including costs of collection.

9. **Change of Custody:** The Patient or Legal Responsible and Financially Responsible Party acknowledge that once custody of products provided by Hartzell's Pharmacy has been transferred over to the Patient, either directly or through an intermediary such as a caretaker and/or family member, Hartzell's Pharmacy can no longer provide any credits or refunds due to federal and state regulations. Change of custody occurs at the point when products provided by Hartzell's Pharmacy are received by, or on behalf of, the Patient, are no longer in control of an employee of Hartzell's Pharmacy, and a signed document of receipt has been completed.
10. **Reliance and Consideration:** Hartzell's Pharmacy is relying upon the Financially Responsible Party's agreement herein in determining to provide products and services to the Patient, and Hartzell's Pharmacy's provision of products and services to the Patient constitutes good and adequate consideration for the Financially Responsible Party's agreements contained in this agreement.
11. **Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations:** The Patient or legal Representative hereby authorizes Hartzell's Pharmacy, its employee, agents and sub-contractors to disclose to the Medicare or Medicaid program or to any other third party payer any medical or other information needed for payment for all products and services provided by Hartzell's Pharmacy to the Patient until payment has been made in full. The Patient or Legal Representative further authorizes Hartzell's Pharmacy, its employees, agents and sub-contractors to use and disclose the Patient's medical and other information for the provision of products and services, for the business operations of Hartzell's Pharmacy, and for the review of Hartzell's Pharmacy's services, including review by accrediting bodies or government agencies.
12. **Modification:** No modification or amendment of this agreement shall be effective unless agreed to in writing by Hartzell's Pharmacy.

Patient and/or Legal Representative Signature of Agreement:

Patient			
	Signature	Date	Printed Name

Legal Representative			
	Signature	Date	Printed Name

 Resident/Authorized Representative Initials: _______________