RESIDENT/RESPONSIBLE PARTY AGREEMENT

BILLING INFORMATION

NAME OF RESIDENT ______________________ ☐ M ☐ F D/O/B __________

COMMUNITY NAME ______________________

NAME OF PERSON TO BE BILLED/POA ______________________

ADDRESS OF PERSON TO BE BILLED/POA ______________________

CITY ______________________ STATE __________ ZIP __________

HOME PHONE OF PERSON TO BE BILLED/POA ______________ RESIDENT PHONE ______________

SOCIAL SECURITY NUMBER OF PERSON TO BE BILLED ______________________

RELATIONSHIP TO RESIDENT ______________________

PAYMENT / INSURANCE INFORMATION

☐ PRIVATE PAY ☐ PRIVATE THIRD-PARTY INSURANCE ☐ MEDICAID ☐ OTHER

INSURANCE CARRIER NAME ______________________ POLICY NO ______________
(COMPANY NAME) (Attach copy of front & back of Insurance Card)

PHARMACY BENEFIT ☐ YES ☐ NO

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree that community personnel are authorized to order purchases and charges on behalf of the above-named resident.
- I agree to pay all charges incurred by the above-named resident that are not paid for by third party payors, including Medicaid, and additional charges for specially-packaged medications.
- I will pay the entire amount due within 30 days of the statement date shown on the monthly billing statement
- I agree that in order for the resident's account to remain active, payment for billed charges must be made promptly pursuant to these terms.
- I understand that the medications furnished to the above-named resident are not packaged in child-proof containers.

I consent to the release of personal and medical information to any third party payor, governmental agency providing benefits, or other person(s)/entity liable for my treatment charges. In addition, I consent to a similar release of information, as shall be necessary, to initiate and continue my use of pharmacy, laboratory, or other community resources, and/or for transfer to another health care facility.

______________________ ______________
(Resident or Responsible Party/Guarantor) (DATE)

As a recurring transaction, you may charge my ☐ Visa ☐ Mastercard ☐ Specify ______________

Card No: ______________________ Expiration Date: ______________

______________________ ______________
(SIGNATURE) (DATE)