Patient Admission Record and Agreement

Facility Name _____
Admission Date _____

Resident Name _____
Room and Bed# _____
SSN# _____
DOB _____
Sex _____
HICN# N/A

FAMILY/RESPONSIBLE PARTY

Patient is solely responsible for financial and legal authorizations: YES ☐ NO ☐
If NO, please list legal representative below:
Name _____ Relation to Resident _____
Address _____
City/State/Zip _____
Telephone _____

A Legal Representative is a person who has been granted the authority in writing by either the Patient or a court of law
To make medical and/or financial decisions on behalf of the Patient.

PRIMARY CONTACT and FINANCIALLY RESPONSIBLE PARTY

Name _____ Relation to Resident _____
Address _____
City/State/Zip _____
Telephone _____

Primary Contact is also Financially Responsible Party: YES ☐ NO ☐
If NO, please list Financially Responsible Party below:
Name _____ Relation to Resident _____
Address _____
City/State/Zip _____
Telephone _____

A Financially Responsible Party is a person, other than the Patient, who agrees to be responsible for payment of
All charges for products and services provided to the Patient.

Other Emergency Information

Patient Admission Record and Agreement

Patient Name:_____ Facility:_____

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

1. **Authorizations:** The Medicine Shoppe and its subsidiaries are authorized to provide the Patient all products and series prescribed or ordered by the Patient's Physician or by the facility. The Patient's requests the products provided by The Medicine Shoppe be dispensed in containers that are not child resistant. The patient requests that the facility and/or The Medicine Shoppe dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to the facility and pharmacy policy as allowed by professional standards and regulations.
2. **Legal Representative:** Legal Representatives will provide The Medicine Shoppe with documentation establishing their legal authority.
3. **Assignment of Benefits:** The Patient or Legal Representative hereby requests and authorizes any third-party payer to make payment directly to The Medicine Shoppe for products and services provided to the Patient.
4. **Payment:** The Patient and Financially Responsible Party are responsible for paying all charges for products and services provided to the patient by The Medicine Shoppe. As a courtesy, The Medicine Shoppe with submit claims to any insurance companies or other third-party payers listed above or of which The Medicine Shoppe is subsequently notified in writing; however, the Patient and Financially Responsible Party are ultimately responsible for paying any charges not covered by insurance or another third party payer. Payment in fill is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law will accrue on all delinquent accounts beginning on the day after the payment is due.
5. **Fees and Expenses:** The patient and Financially Responsible Party are responsible for paying all costs and expenses incurred by The Medicine Shoppe in the collection of amounts owed and the enforcement of its rights under this agreement, including without limitations, attorney's fees, court costs and expenses.
6. **Assurance of Payment; Termination of Services:** The Patient or Legal Representative and Financially Responsible Party acknowledge that if the Patient and Financially Responsible Party are delinquent on payment of any amount owed to The Medicine Shoppe, The Medicine Shoppe may, in its sole discretion, do either or both of the following: (a) condition its continued provision of products and series to the Patient upon The Medicine Shoppe's receipt of assurance of payment acceptable to The Medicine Shoppe; and/or (b) suspend or terminate its provision of products and series to the Patient. Such suspension or termination will in no way affect the Patient's or Financially Responsible Party's obligations to pay all amounts owed under this agreement, including cost of collection.
7. **Reliance and Consideration:** The Medicine Shoppe is relying upon the Financially Responsible Party's agreements herein in determining to provide products and services to the Patient, and The Medicine Shoppe provision of products and services to the Patient constitutes good and adequate consideration for the Financially Responsible party's agreements contained in this agreement.
8. **Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations:** The Patient or legal Representative hereby authorizes The Medicine Shoppe and its employees, 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 The Medicine Shoppe to the Patient until payment has been made in fill. The Patient or Legal Representative further authorizes The Medicine Shoppe, 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 The Medicine Shoppe and for the review of The Medicine Shoppe's services, including review by accrediting bodies or governmental agencies
9. **Modifications:** No modification or amendment of this agreement shall be effective unless agreed to inwriting by The Medicine Shoppe.

Patient/Legal Representative Name	Signature		Date
Legal Representative Relationship to Patient	Street Address	City, State, Zip Code	Reason for Signing
Financially Responsible Party Name	Signature		Date

FORMD-5

Acknowledgment of Receipt of Notice of Privacy Practices

Secundum Artem Enterprises, Inc.
d/b/a The Medicine Shoppe® Pharmacy
821 Scioto Street
Urbana, OH. 43078

Patient Name _____ Facility Name _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

My signature below certifies that I have been provided with a written copy of the above named pharmacy's Notice of Privacy Practices.

Patient Signature (or authorized representative) _____ Date _____

If the patient or patient representative refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the patient's acknowledgment and the reasons why they could not sign;

☐ Patient/representative refused to sign

☐ Patient/representative unable to sign acknowledgment

☐ Other (explain): _____

Signature (person attempting to obtain) _____ Date _____

Statement to Permit Payment of Medicare Benefits
to Provider, Physicians, and Patient

Beneficiary Name: _____
HICN#: _____
Account#: _____
Facility: _____
Start Date: _____

I request that payment of authorized Medicare benefits be made to Secundum Artem Enterprises, Inc. d/b/a The Medicine Shoppe Pharmacy and/or its corporate affiliates for any service, equipment, or supplies furnished me by The Medicine Shoppe.

I authorize release of any medical information (including copies thereof) by or to The Medicine Shoppe necessary to process claims for services, equipment and supplies provided by the Medicine Shoppe.

This authorization allows The Medicine Shoppe to release this information or any other information needed to determine the benefits, coverage, reimbursement and/or payment for related services, equipment or supplies to the Centers for Medicare and Medicaid services, or its agents, or any private or secondary insurance agency or their respective agents.

I authorize release by the Social Security Administration and any of its agencies to The Medicine Shoppe information regarding my Medicare coverage and any related claims coverage information.

_____ _____
Beneficiary Signature Date

If beneficiary is unable to sign, the following information must be completed:

_____ By: _____ _____
Beneficiary's Name Authorized Representative Date

_____ _____
Address of Representative Relationship

_____
Reason for Inability to Sign