



Name _____

D.O.B. _____

Patient Information/Service Agreement

A. Billing Authorization

- Medicare. I request and authorize that payment under the Medicare program be made directly to Merwin LTC Pharmacy for the services provided to me. As the caregiver or authorized representative, I do fully understand that the patient and/or their estate are responsible for the deductible amount as required under part "B" of Medicare. I agree to reimburse Merwin LTC Pharmacy for any portion of the deductible that Medicare subtracts from the services I am receiving. I understand that I am also responsible for co-insurance, which is 20% of the approved charges that Medicare does not pay.
- Insurance. I authorize payment of my insurance benefits directly to Merwin LTC Pharmacy, but such payments and co-payments shall not exceed the regular charges of Merwin LTC Pharmacy. I understand that I am financially responsible to Merwin LTC Pharmacy for charges not covered by my insurance. I have received information discussing the fees, to cover the services(s) I will be receiving, provided by Merwin LTC Pharmacy.

B. Acknowledgment of Receipt for Privacy Disclosure Notice and Consent to Treat.

- I request the services of Merwin LTC Pharmacy as authorized by my physician. I consent to the release of my Merwin LTC Pharmacy records in order to assure continuity of treatment, proper reimbursement of services, and communication of information to my physician and referral source: (1) To Medicare or my insurance company for purposes of payment of my medical service costs; (2) To representatives of other health providers involved in my healthcare; (3) To the State, Federal, accrediting bodies and contracted reporting vendors for required reporting data and/or surveys for compliance (4) To the courts, if subject to an order; (5) To any emergency care provider in the event of a medical emergency in which information is necessary and prudent for my emergency care; (6) As mandated by the State Vulnerable Adult/Child Acts; (7) I authorize any holder of medical or other information for this or a related Medicare claim.

C. Emergency Plan: Pharmacy is open 24 hours every day. Our 24 hour telephone is (651) 639-0608.

- Notify the office regarding health changes, schedule changes (including physician appointments and other appointments) which may affect scheduled services and/or a need for additional services. (1) Call your physician to report symptom changes or problems. (2) For any life threatening medical emergency call 911; (3) If a medical emergency arises during a home visit, staff have been directed to provide emergency care, call 911, or the physician unless a health care directive of DNR/DNI orders specify not to seek emergency care.

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- I have received and understand how to contact the company for emergency and other services.
 - I have participated and understand my medical orders/plan of care.
 - I have received oral or written instructions on the use and care of the supplies and services.
 - I have been provided a copy of the Patient Bill of Rights, Medicare Provider Standards, Patient Responsibilities, Complaint/Grievance Procedure and contacts. [HIPPA Privacy Notice]
 - All financial issues and my potential financial obligations have been explained to me.
 - I have read and understand the service agreement.

Items Supplied: _____

Patient/authorized Representative Signature _____ Date _____

Assumption of signature; I _____ have signed for _____

The patient could not sign due to _____ Relationship _____