



Patient Payment Guarantee Form

PATIENT NAME: \_\_\_\_\_ FACILITY: \_\_\_\_\_

Merwin LTC Pharmacy (referred to herein as "Pharmacy") agrees to provide to the resident all pharmaceutical services as needed. Medication is packaged via a unit dose system.

Pharmacy will maintain a current drug profile on the resident, provide free delivery service and 24-hour emergency service. IV services may include, but are not necessarily limited to venipuncture, catheter care, assessment and monitoring. I hereby authorize these services to be rendered to the resident for whatever period of time the physician deems necessary.

In consideration for the agreement of the Pharmacy to provide medications and supplies to the above patient on an open account, (I/We) do hereby unconditionally guarantee payment to the Pharmacy for all medications and supplies purchased from the same and supplied to the above-named patient while a resident at the above name Facility.

(I/We) understand that all bills are due upon receipt. If not paid within 30 days of billing date, a 1.5% finance charge (18% per annum) or a minimum service charge of \$.25 will be assessed. (I/We) also agree to pay any legal fees and court costs incurred in the collection of this account.

I authorize any holder of medical and/or insurance information about me to disclose such information to the Pharmacy. I further authorize the Pharmacy to disclose any medical and/or insurance information concerning me in its possession: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payor who may be responsible for payment or Pharmacy services.

I authorize the Pharmacy to request on my behalf all public and private insurance benefits for products/services supplied to me by the Pharmacy. I further authorize payment for such products/services to be made directly to the Pharmacy.

**I will provide Merwin LTC Pharmacy a copy of my insurance card (front and back) for billing purposes.**

Insured's Name: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

**\*\* Responsible Party Signature Required \*\***

Responsible Party (print): \_\_\_\_\_

Responsible Party (sign): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

AMEX/Discover/Mastercard/Visa # \_\_\_\_\_ Exp Date: \_\_\_\_\_

I authorize Merwin LTC Pharmacy to use for monthly pharmacy charges: \_\_\_\_\_

Cardholder/Power of Attorney