528 N. Broadway
Escondido CA 92025

Phone: 760.489.7077
Fax: 760.291.1114

Advance Care
PHARMACY

Long-term Care Facility

Name:_____ Facility:_____

(Circle one) Visa / Mastercard / Discover / Am. Express

Credit Card #_____ **Exp.Date:**_____

Cardholder's Name_____

Billing Address_____

Security Code_____ **Date Signed:**_____

Mandatory Authorized Signature:_____
(By signing above, I authorize Advance Care Pharmacy to charge the credit card listed above)

Authorization for Credit Card

ADVANCE CARE PHARMACY, agrees to provide medications and other pharmacy items ordered by the patient's physician in accordance with the following terms:

1. The patient and/or responsible party unconditionally guarantees to pay ADVANCE CARE PHARMACY, for all charges incurred as a result of the medications and/or pharmacy items ordered by the patient's physician, caregiver, family, or purchased from the pharmacy while patient is under the care of ( )
2. Responsible party will notify ADVANCE CARE PHARMACY, of any changes in insurance coverage or pay status immediately, and provide the new carrier's coverage information. If third party does not pay for any reason, the responsible party will be liable for payment of services rendered.
3. Payment for services rendered is due upon delivery or pickup of the medication. Responsible party also agrees to pay any legal fees and court costs incurred in the collection of this account.
4. ADVANCE CARE PHARMACY reserves the right to discontinue service to the patient for any account with a past due balance.
5. ADVANCE CARE PHARMACY has my permission to bill the appropriate payer identified (above) for medications and other pharmacy items or services furnished for my care.

THE UNDERSIGNED CERTIFY THAT HE/SHE/THEY HAVE READ THE ABOVE AND HEREBY ACCEPT ALL TERMS AND CONDITIONS CONTAINED HEREIN.

Responsible Party (sign) _____

Address_____**City**_____ **Zip Code**_____

Home Tel:_____ **Work Tel:**_____

Fax:_____ **E-Mail:**_____

Witness:_____ **Date**_____

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It is with great pleasure that we welcome you to Advance Care Pharmacy, Advance Care Pharmacy is committed to providing our customers with quality pharmaceutical services; our staff will provide you with superior customer service in an effort to provide you with high quality care.

Enclosed is **Financial Responsibility Agreement.** This form requires patient information, Prescription insurance information (please provide a copy of the front and back of insurance card), the responsible party and billing address. We must have this before filling any medication orders.

We will bill your credit card (VISA, MasterCard, Discover or Amx) on a monthly schedule. This information can be supplied to us on the Financial Responsibility Form previously mentioned. Please remember that any insurance information omitted from this form releases Advance Care Pharmacy, from complying with the requirements of the carrier.

Advance Care Pharmacy, understands that it can be a stressful time for you and your family. If you have any questions or need assistance in completing this form, we can be reached Monday through Friday 9:00am to 6:00pm at 760-489-7077 option 5. or ext. 324

We look forward to serving the pharmacy needs of you or your loved one.

Sincerely,

Staff of Advance Care Pharmacy

FINANCIAL RESPONSIBILITY AGREEMENT

BY AND BETWEEN ADVANCE CARE PHARMACY,
and

Patient._____ **Sex**_____

Facility:_____

Ssn:_____ **Dob:**_____

Allergies:_____

Responsible party

PHARMACY MUST HAVE CORRECT BILLING INFORMATION **UPON ADMISSION**
For prescription card insurance, please provide a copy of card (front and back) and the ID#. Failure to provide this information releases Advance Care Pharmacy, from complying with the requirements of the carrier.

Insured's ID#_____ **Group #**_____
(Prescription card)
Insurance Co. _____ **Phone:**_____