WELCOME!

Welcome to [community] _____! We use Guardian Pharmacy of South West Florida (SWFL) as our pharmacy provider. Through our partnership with Guardian Pharmacy of SWFL, we can deliver the best possible service and ensure you get the medications you need, when you need them, safely – and at the right price.

WHY USE GUARDIAN?

- **Cost Management** – Guardian coordinates directly with your physicians and third-party insurance providers to ensure minimal out-of-pocket medication costs
- **Billing Support** – Unlike a retail pharmacy, Guardian bills medications monthly, and their local billing staff is always ready to answer billing-related questions
- **Medicare Guidance** – The pharmacy helps you understand your Medicare Part D coverage and can offer one-on-one consultations during open enrollment
- **Clinical Support** – Guardian conducts ongoing medication reviews to ensure you're on the appropriate drug regimen
- **Compliance Packaging** – Easy-to-use packaging options, required by our community, organize your medications and minimize the risk of error
- **Timely Delivery** – Scheduled and emergency deliveries are available 24/7, eliminating trips to a local retail pharmacy
- **Integrated Technology –** Guardian's seamless integration of our community's electronic medication administration record (eMAR) system eliminates transcription errors and improves medication management

Guardian Pharmacy of SWFL designs services to make sure you never have to worry about your medication needs. That's why [community] _____has chosen Guardian Pharmacy of SWFL as our preferred pharmacy provider.

In order to receive service by Guardian Pharmacy of SWFL, please complete the enclosed paperwork and email, fax or mail to the pharmacy by [date]: _____

GUARDIAN PHARMACY OF SWFL
24451 SANDHILL BLVD. UNIT A, PUNTA GORDA, FL 33983
INFO.SWFL@GUARDIANPHARMACY.NET
855-374-7844 fax
941-255-1987 phone

If you do not want to use Guardian Pharmacy of SWFL Services as your provider, you have the choice to opt out of their services. However, using any pharmacy other than Guardian Pharmacy of SWFL Services may incur a **$**_____ fee. If you still wish to use another pharmacy, please sign and return the pharmacy opt-out letter to our community staff.

Thank you,

Name: _____
Executive Director
Community: _____

PHARMACY SERVICES AGREEMENT

GUARDIAN PHARMACY OF SWFL
24451 SANDHILL BLVD. UNIT A, PUNTA GORDA, FL 33983
941-255-1987 phone | 855-374-7844 fax

This is an agreement for pharmacy services with GUARDIAN PHARMACY OF SWFL and

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for GUARDIAN PHARMACY SWFL's agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize GUARDIAN PHARMACY OF SWFL, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by GUARDIAN PHARMACY OF SWFL. GUARDIAN PHARMACY OF SWFL does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, GUARDIAN PHARMACY OF SWFL may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize GUARDIAN PHARMACY OF SWFL to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of GUARDIAN PHARMACY OF SWFL supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by GUARDIAN PHARMACY OF SWFL. If, for any reason, GUARDIAN PHARMACY OF SWFL does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay GUARDIAN PHARMACY OF SWFL directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account.
5. **PAYMENT OF BENEFITS.** I authorize GUARDIAN PHARMACY OF SWFL to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to GUARDIAN PHARMACY OF SWFL.
6. **ASSIGNMENT OF BENEFITS.** I authorize GUARDIAN PHARMACY OF SWFL to request and collect on my behalf all public and private benefits due for the products and services supplied by GUARDIAN PHARMACY OF SWFL. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to GUARDIAN PHARMACY OF SWFL.
7. **UNPAID INVOICES.** GUARDIAN PHARMACY OF SWFL encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by GUARDIAN PHARMACY OF SWFL related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** GUARDIAN PHARMACY OF SWFL reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to GUARDIAN PHARMACY OF SWFL any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by [PHARMACY NAME]. I also authorize all medical personnel to disclose information to GUARDIAN PHARMACY OF SWFL relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to GUARDIAN PHARMACY OF SWFL to use or disclose certain aspects of my health information to: the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of GUARDIAN PHARMACY OF SWFL's privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that GUARDIAN PHARMACY OF SWFL is committed to protecting my health information. I certify that I have read and understand this agreement:

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of GUARDIAN PHARMACY OF SWFL's Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item. I have been given the opportunity to and did examine the Medicare Capped rental and inexpensive or routinely purchased items notification and was given an opportunity to ask questions to assist my understanding of it.

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify that I have received a copy of GUARDIAN PHARMACY OF SWFL's Injury, infection, and emergency preparedness protocol and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

PAYMENT INFORMATION

I certify that I have received a copy of GUARDIAN PHARMACY OF SWFL's payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

I UNDERSTAND AND HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES, THE NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES, THE MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS, INJURY, INFECTION AND EMERGENCY PREPAREDNESS, AND THE PAYMENT INFORMATION DOCUMENTS AND AGREE TO BE BOUND BY THEM.

Signature [Resident or Responsible Party]**:** _____ **Date:** _____

RESIDENT ENROLLMENT FORM

RESIDENT INFORMATION

RESIDENT NAME _____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# _____-_____-_____ DOB _____/_____/_____ MEDICARE ID# _____ ☐MALE ☐FEMALE

COMMUNITY NAME _____ APT# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER _____

**A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE*

RESPONSIBLE PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____
[STREET] [CITY] [STATE] [ZIP CODE]

**MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS*

SECONDARY* _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

**SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT*

RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

A valid credit card or ACH payment method is required to be kept on file to secure this account. Please fill out one of the boxes below based on your preferred payment method.

ACH / Checking Account

NAME OF BANK _____ NAME ON ACCOUNT _____

ROUTING NUMBER _____ ACCOUNT NUMBER _____

Credit Card

TYPE OF CARD: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

NAME ON CARD _____ CARD NUMBER _____

BILLING ADDRESS _____ EXPIRATION (MMYY) _____/_____

_____ SECURITY CODE_____

*VISA/MC/DISCOVER: 3 digits on back of card
*AMEX: 4 digits on front of card

Please select an option below and sign.

☐ *I wish to pay automatically by credit card each month – please enroll me in auto-pay.*

☐ *I wish to pay automatically by electronic check each month – please enroll me in auto-pay.*

☐ *I will mail in payment by check each month, pay monthly via online credit card portal, or call to pay by phone each month, promptly after receipt of Guardian's statement. **

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE

THE RIGHT TO CHOOSE YOUR PHARMACY PROVIDER

PHARMACY OPT-OUT

Your community has chosen GUARDIAN PHARMACY OF SWFL as its preferred pharmacy because of the outstanding service we provide to our residents. However, the Centers for Medicare and Medicaid Services (CMS) guarantees a beneficiary his or her right to a choice of pharmacy providers. We sincerely hope you choose GUARDIAN PHARMACY OF SWFL as your provider, but we will honor your choice if you prefer another provider.

This form is only for those who do NOT wish to receive their medications from GUARDIAN PHARMACY OF SWFL and would like to "opt-out" or decline the services provided by GUARDIAN PHARMACY OF SWFL.

By signing this form, you are acknowledging the following:

- You are choosing to use a pharmacy provider that is not GUARDIAN PHARMACY OF SWFL.
- You agree to assume the responsibility of tracking, ordering, and having prescription medications delivered to your community.
- You agree to incur the fee charged by your community each month for utilizing a non-preferred pharmacy.
- If a prescribed medication is not available for administration, I consent [COMMUNITY] _____ to order a 7-day supply from GUARDIAN PHARMACY OF SWFL at my cost while I arrange to have another provider deliver a full supply of the medication. [COMMUNITY] _____ is obligated by the State of FLORIDA to administer medications as they are ordered and an excuse of "not available" is not permissible.

If you would like to use your community's preferred provider, GUARDIAN PHARMACY OF SWFL please disregard the signature block below. Sign below ONLY if you wish to use a pharmacy other than GUARDIAN PHARMACY OF SWFL

_____ _____

Resident/Responsible Party Date

_____ _____

Community Representative Date

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

As our customer, you are hereby provided this Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. We fulfill our obligation to protect and promote the rights of our patients, including the following:

RIGHTS: As the patient/caregiver, you have the right to:

- Be treated with dignity and respect
- Confidentiality of patient records and information pertaining to a patient's care
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care
- Be notified in advance of any change in your plan of care and treatment
- Be provided equipment and service in a timely manner
- Receive an itemized explanation of charges
- Be informed of company ownership
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property
- Be informed of potential reimbursement for services under Medicare, Medicaid or other 3rd party insurers based on the patient's condition and insurance eligibility
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third-party insurers. (to the best of our knowledge)
- Be notified within 30 working days of any changes in charges for which you may be liable
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed, if Guardian Pharmacy of Anaheim is unable to provide services then we will provide alternative resources
- Purchase inexpensive or routinely purchased durable medical equipment
- Expect that we will honor the manufacturer's warranty for equipment purchased from us
- Receive essential information in a language or method of communication that you can understand
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law

CLIENT RESPONSIBILITIES: As the patient/caregiver, you are RESPONSIBLE for:

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participation as in the plan of care/treatment.
- Notify the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses,
- hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

OUR RIGHTS: As your pharmacy of choice, we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our pharmacy to secure medication or durable medical equipment.
- To refuse services to anyone who enters our pharmacy and is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.