Phone 877-684-9987

Fax 877-455-5550

PATIENT PAYMENT GUARANTEE

RESIDENT NAME: **FAILITY**

Middle Tennessee Pharmacy Services (referred to herein as "Pharmacy") agrees to provide to the resident all pharmaceutical services as needed.

Pharmacy will maintain a current drug profile on the resident, and provide delivery service and 24-hour emergency service.

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) 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 payer who may be responsible for payment or Pharmacy services.

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Insured's Name:

Insurance Company Name: **Social Security#**

ID# **Group #**

Insurance Company Phone# **Date of Birth**_____

Insurance Company Address

****RESPONSIBLE PARTY SIGNATURE REQUIRED****

Responsible Party (print): **Relationship to Resident:**

Responsible Party (sign):_____

Address:

City: **State:** **Zip:**

Telephone Number: ( ) **Alternate Telephone Number( )**

Witness: **Date:**