PHARMACY SERVICES AGREEMENT

MIDDLE TENNESSEE PHARMACY SERVICES
661 E LANE ST
SHELBYVILLE, TN 37160
P: 877.684.9987 F: 877.455.5550

This is an agreement for pharmacy services with [MTPS] and

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

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

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize [MTPS], 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 [MTPS]. [MTPS] 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, [MTPS] 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 [MTPS] 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 [MTPS] 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 [MTPS]. If, for any reason, [MTPS] 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 [MTPS] 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 [MTPS] 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 [MTPS].
6. **ASSIGNMENT OF BENEFITS.** I authorize [MTPS] to request and collect on my behalf all public and private benefits due for the products and services supplied by [MTPS]. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to [MTPS].
7. **UNPAID INVOICES.** [MTPS] 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 [MTPS] related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** [MTPS] 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 [MTPS] 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 [MTPS]. I also authorize all medical personnel to disclose information to [MTPS] relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to [MTPS] 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.

I have read and understand the above terms and conditions and agree to be bound by each of them:

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