PHARMACY SERVICES AGREEMENT

Preferred Care Pharmaceutical Services
4794-A Highway 162, Hollywood, SC 29449
FAX: 1(800)741-3371 or 1(843)769-5728
PHONE: 1(888)747-8950 or 1(843)769-6522

Thisis anagreementforpharmacyserviceswith Preferred Care Pharmacy and

_____and_____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for the agreement to provide medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Preferred Care Pharmacy 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 Preferred Care Pharmacy. Preferred Care Pharmacy 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, Preferred Care Pharmacy 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 Preferred Care Pharmacy to share any necessary patient health information related to me with my facility or physician. I also authorize facilitypersonneltopurchase medications,or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of Preferred Care Pharmacy supplying me with physician-requested products or services, I agree and accept responsibility for the payment of allsums that may become due for medications provided to me by [PHARMACY NAME]. If, for any reason, Preferred Care Pharmacy 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 Preferred Care Pharmacy 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 Preferred Care Pharmacy to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay forall coveredprescriptionsor durable medical equipment. I further direct my insurancecarrier or third-party payor to issue any payments directly to Preferred Care Pharmacy.
6. **ASSIGNMENT OF BENEFITS.**I authorize Preferred Care Pharmacy to request and collect on my behalf all public and private benefits due for the products and services supplied by Preferred Care Pharmacy. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Preferred Care Pharmacy.
7. **UNPAID INVOICES.** Preferred Care Pharmacy 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 Preferred Care Pharmacy related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Preferred Care Pharmacy reserves the right to discontinue services to my account if I have not paid the account in fullwithin 60 days.Paymentsthat remaindelinquent maybeturned over tocollections.
9. **RELEASE OF INFORMATION.**I authorize any insurer or third-party payor who provides me with coverage to disclose to Preferred Care Pharmacy 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 Preferred Care Pharmacy. I also authorize all medical personnel to disclose information to Preferred Care Pharmacy relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.**I give permission to Preferred Care Pharmacy 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:**_____

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

I certify thatI have received a copy of Preferred Care Pharmacy's privacy practices and have been given an opportunity to review the document and ask questionstoassistmy understanding of resident's rightsrelativetotheprotectionof resident'shealth 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 Preferred Care Pharmacy is committed to protecting my health information. I certify that I have read and understand this agreement:

_____**Resident or responsible Party Initial**

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify thatI have received a copy of Preferred Care Pharmacy 's Notice of Non-Discrimination and Complaint Proceduresand have been given an opportunity to and didreview the document including the free disabilities aids and language services available and was given an opportunity to ask questionstoassistmy 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.

_____**Resident or responsible Party Initial**

MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS

IreceivedinstructionsandunderstandthatMedicaredefinesthe _____that Ireceivedasbeingeitheracappedrentaloraninexpensiveorroutinelypurchased 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 questionstoassistmy understanding of it.

_____**Resident or responsible Party Initial**

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify thatI have received a copy of Preferred Care Pharmacy Injury, infection, and emergency preparedness protocol and have been given an opportunity to and didreview the documentand was given an opportunity to ask questionstoassistmy understanding of it.

_____**Resident or responsible Party Initial**

PAYMENT INFORMATION

I certify thatI have received a copy of Preferred Care Pharmacy's payment information and understand the available ways to pay my bills and have been given an opportunity to and didreview the documentand was given an opportunity to ask questionstoassistmy understanding of it.

_____**Resident or responsible Party Initial**

I understand and have reviewed all of the above documents and agree to be bound as applicable.

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