BILLING AGREEMENT

Saliba's Extended Care Pharmacy services include but are not limited to providing prescriptions, maintaining and providing medication administration records, free delivery service, IV services, consultations by our pharmacist, nursing staff, and affiliates and 24-hour emergency service. IV services may include venipuncture, catheter care, assessment and monitoring.

Itemized statements are sent out at the beginning of each month for prescriptions sent the previous month. The statements reflect all costs not paid by the insurance including co-pays, and the cost of prescriptions not covered by insurance. The balance due is payable directly to Saliba's Extended Care Pharmacy upon receipt but no later than the 25th of each month. Any discrepancies shown on the statement must be communicated to the pharmacy within 30 days so we may attempt to resubmit the claim electronically. Depending on the plan, the claim may need to be manually submitted to the plan by the responsible party for reimbursement if the plan will not allow us to submit the claims electronically.

PATIENT INFORMATION

(Required)

Patient Name: _____ Patient DOB: _____

Name of Assisted Living or Skilled Nursing Facility:

AUTOMATIC PAYMENT

(Optional)

☐ **By providing payment information, I authorize Saliba's Extended Care Pharmacy to automatically charge monthly balances to the payment account listed below.** *(Please check box and complete fields below for autopay)*

Payment Accountholder Name (per check/debit/credit card): _____

Address payment account statement is mailed to: _____

Email: _____

☐ Credit/Debit Card#: _____ Exp: _____ CCV*: _____

-OR-

☐ Bank Name: _____ Routing# _____Checking Acct#: _____

**CCV is the last 3 digits of the number on back of card in the signature panel. American Express is the exception with 4 digits on the* front *of card.*

RESPONSIBLE PARTY INFORMATION

(Required)

RESPONSIBLE PARTY NAME *(if different from patient)* _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

RESPONSIBLE PARTY *(signature)* **_____ Date: _____

By signing this agreement, you agree to receive service from Saliba's Extended Care Pharmacy and guarantee payment for services rendered. If payment is made to you for services rendered by Saliba's Extended Care Pharmacy, you will transfer the payment to Saliba's Extended Care Pharmacy and authorize any applicable pharmacy benefits to be paid directly to Saliba's Extended Care Pharmacy. You also agree to pay any legal fees and court costs incurred in the collection of this account.

***Billing Agreement void without signature. Patient or Responsible Party must sign.*