10929 Hwy 301 S., Suite 111 Statesboro, GA 30458
Telephone: 912-764-7839 / Toll Free: 877-736-2233
Fax: 912-489-1519/ Toll Free: 866-534-5566
Website: www.guardianpharmacysouthga.com

PHARMACEUTICALS PURCHASE AGREEMENT

Name of Resident:	Primary Care Physician:	
Resident's SSN:		Date of Birth :

PLEASE SUPPLY A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD AND OR MEDICARE –PART-D AND MEDICARE CARD.

PRESCRIPTION CARD/MEDICAID/MEDICARE/TRICARE ID #'S:

Facility:	Room:	Unit:
Previous Pharmacy:	Location:	

- I understand that the use of Guardian as a provider of pharmaceuticals and other necessities is optional.
- I understand that approved patient package inserts are available upon request.
- I agree I have received a copy of Guardian's privacy practices and have had the opportunity to review the document and ask questions to assist my understanding of the resident's rights relative to the protection of the resident's health information.
- I agree I have read the privacy practices for Guardian and certify that I am the resident, or authorized by the resident as the resident's general agent to execute the above conditions and accept its terms.
- I authorize facility personnel to make purchases on this account on behalf of the named resident
- I understand that this document must be on file in order for the pharmacy to provide any resident's medication and/or supply orders.

I agree to the following regarding purchases and select a payment option below. If none is selected, customer will be enrolled in the automatic monthly payment plan.

☐ **I elect to have my card processed monthly for balance due.**

☐ **I will pay the entire amount due for any purchases made within 15 days of the statement date shown on the monthly billing statement.**

- **If account becomes more than 45 days past due, credit card will be charged for the entire balance due.**
- **I agree that in order for the account to remain active, the account must remain current, and I understand that no additional purchases will be allowed when it becomes 30 days past due.**

Responsible Party Name:		
Home Phone:	Cell Phone:	Other Phone:
Email:		
Billing Address:		
City:	State:	Zip:

Valid credit card is required to secure this account-kept on file

Credit Card #:	Security Code:	Exp. Date:

RESPONSIBLE PARTY SIGNATURE:_____DATE_____