Southern PHARMACY SERVICES
A Guardian Pharmacy®

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Resident Information (Please Print):

Resident Name:_____Facility Name: _____

Date of Birth:_____ Soc. Sec. #: _____ Medicare #: _____

Please attach copies of resident's active insurance cards.

Check ANY that apply:

☐ No Pharmacy Insurance ☐ Medicaid Pending ☐ I will provide my own OTCs
☐ I use another pharmacy (VA, mail order, etc.)

Billing Information (Please Print):

Name (if not resident): _____ Relationship: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number:_____ Email Address: _____

Additional parties with whom SPS may discuss billing matters: _____

_____

Pharmacy Admission Agreement

All accounts are due and payable 25 days after the statement date. All payments are to be made directly. Should the account be referred to collection, the undersigned agrees to pay reasonable costs in such a collection effort. Southern Pharmacy Services reserves the right to discontinue providing services for those accounts that are in excess of 90 days delinquent. Should the patient need help enrolling in Medicare Part D, Southern Pharmacy can assist in that process.

I understand that the use of Southern Pharmacy Services as a provider of pharmaceuticals and other necessities is optional. I also understand that Patient Inserts are available upon request.

I agree to the following for all purchases:

1. I will pay the entire amount within 25 days of the statement date.
2. I will pay for any purchases not payable by Insurance, Medicaid or Medicare.
3. I agree that in order for the account to remain active, the account must remain current.
4. I authorize facility personnel to make purchases on this account on behalf of the named resident.
5. I understand that this document is to be submitted to the pharmacy within 72 hours of admission.

Signature below is indication that you wish to use pharmacy services provided by Southern Pharmacy Services. If you do NOT wish to use SPS for pharmacy services, please opt out below:
❑ I DO NOT wish to use pharmacy services provided by SPS for primary prescription services.

Acknowledgement of Notice of Privacy Practices

The undersigned acknowledges that he/she has received a copy of Southern Pharmacy Services Notice of Privacy Practices. In addition to the attached document, the notice can be found at www.southrx.com.

Signature of Responsible Party: _____ Date _____

Print Name _____

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Why You Should Use Southern Pharmacy to Provide Resident's Medication

- **Advantages for a resident to use Southern Pharmacy**
  - Medical Records/eMAR continuity with orders versus packaged product
  - Consistent medication packaging
  - No family delivery or pickup
  - All RX labeling requirements met
  - Consulting RPh chart reviews
  - Improved efficiency of med order placement and timely pharmacy delivery
  - 24/7 availability
  - Knowledge of DHHS regulations
- **Experts in LTC processes – procedures**
  - Refill due reports
  - Therapeutic substitution
  - Insurance billing and authorization
  - Communication to staff
  - Survey assistance
  - Yearly assistance with Medicare Part D resident assignments