SOUTHERN PHARMACEUTICAL SERVICES™
GUARDIAN PHARMACY OF BIRMINGHAM

1950 Crestwood Boulevard Birmingham, AL 35210
Insurance & Billing Department: 205-451-1829
Fax: 205-451-1823 • www.spsrx.net

NEW RESIDENT INSURANCE INFORMATION

RESIDENT NAME: _____ **FACILITY:** _____

Date of Birth: _____ Social Security #: _____

Primary Prescription Insurance:

_____

Telephone Number: (____) _____
ID#: _____
Group #: _____
BIN: _____
PCN: _____

Secondary Prescription Insurance:

_____

Telephone Number: (____) _____
ID#: _____
Group #: _____
BIN: _____
PCN: _____

Hospice Provider Information: *If resident is enrolled in hospice please provide the following information:

Name of Hospice Provider: _____ Telephone Number: (____) _____

*PLEASE INCLUDE A COPY OF THE INSURANCE CARD BOTH FRONT AND BACK.

Responsible Party for Payment & Primary Contact Person – your Statement will be mailed to this address:

Name: _____ Relationship to Resident: _____

Phone: _____ (Home/Cell) Circle Email: _____

Address: _____
(Street) (City) (State / Zip)

Alternate Responsible Party– MUST be completed if Resident is listed as responsible party

Name: _____ Relationship to Resident: _____

Phone: _____ (Home/Cell) Circle Email: _____

Address: _____
(Street) (City) (State / Zip)

☐ **I wish to pay automatically by credit card each month***

☐ I will mail in payment by check promptly after receipt of SPS statement. I understand my credit card will only be used after SPS notifies responsible party about non-payment of an outstanding balance.

Type of card (circle): **Visa / MasterCard / American Express / Discover**

Name on Card: _____ **Billing Address:** _____

Card # _____ **Expiration** _____ **Security Code*** _____
- **VISA/MC/Discover**: 3-digits on back of card
- **Amex:** 4-digits on front of card

*I wish to pay automatically by credit card each month. I authorize Southern Pharmaceutical Services to charge my credit card for the balance of charges not paid by my insurance company. Southern Pharmaceutical Services will charge the balance due about 10 days after statements have been mailed to allow time to review the statement and communicate any issues/concerns. / Accepted by: Philip Boyd, President for Southern Pharmaceutical Services.

Southern Pharmaceutical Services (SPS) will provide medications and supplies to the above patient on an open account. I/We do unconditionally guarantee payment to SPS for all medications and supplies purchased from the same and supplied to the above named patient. I/We understand that all bills are due upon receipt. Finance charges may apply to all unpaid balances after 30 days from billing date. I/We agree to pay any legal fees and court costs incurred in the collection of this account.

Additionally, I/we authorize any holder of medical and/or insurance information about the above named to disclose such information to SPS. I further authorize SPS to disclose any medical/or insurance information: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third party payer who may be responsible for payment or Pharmacy services.

I authorize SPS to request on my behalf all public and private insurance benefits for products/services and authorize payment be made directly to SPS. I agree to provide SPS a front & back copy of my insurance card for billing purposes.

I hereby acknowledge that I have reviewed a copy of this pharmacy's Notice of Privacy Practices at www.spsrx.net.

Responsible Party Signature: _____ **Date:** _____

*Signature Required