PHARMACY SERVICES PROVIDER AGREEMENT

*Named Patient*_____ *Facility Name* _____

I, _____, authorize Connect Pharmacy, and any other pharmacies owned by Connect LTC Pharmacy (referred to in this agreement as the "Pharmacy") to provide medications and associated products and services to the above-named Patient. I certify that I have the legal authority to sign this agreement on behalf of said Patient and I understand that by signing this agreement I will become responsible to pay the usual and customary fee for all medications, products and services provided to the Patient by the Pharmacy at the direction of the facility administration and staff and attending physicians(s). If I disagree with any medication, product or service directed by the facility or an attending physician, I will contact them and resolve the issue(s) and ask them to provide different written direction to the Pharmacy. I acknowledge and agree that the Pharmacy provides medications, products or services based upon the most current written direction received by it.

For Patients receiving benefits from an insurance company (referred to in this agreement as a Pharmacy Benefits Manager ("PBM"), I am aware that the Pharmacy will bill the PBM for all medications, products and services covered by the PBM and that I am responsible for any co-payments that may apply and/or for the payment for all medications, products and services and services provided by the Pharmacy that are not covered by the PBM. Should I arrange for home health and/or hospice services and supplies, I understand that Medicare will not reimburse me, or my supplier and I will be responsible for their cost as well.

I also understand that in addition to billing the PBM , the Pharmacy will also bill me or a regular (normally monthly) basis for all charges for which I am responsible on behalf of the Patient. The invoice will show all charges billed, payments received, and any adjustments required to the patient's account over the previous billing period, plus any balance forward. I agree to pay the Pharmacy in full within 15 days of the monthly statement date. I acknowledge and agree that any account balance over thirty (30) days past due shall be assessed a one-time late fee of Twenty-Five Dollars ($25.00) and shall also accrue interest on the account balance and the late: fee at the rate of 1.5% per month until paid in full. I also understand that if the account balance has not been paid within sixty (60) days of any invoice, the Pharmacy has the option to discontinue providing additional medications, products or services to the above-named Patient. Regardless of whether the Pharmacy still provides medications, products or services to the Patient, if the Pharmacy is required to pursue legal action to collect any balance due from me on behalf of the Patient, I agree to pay reasonable attorney and collection agency fees and costs incurred in collecting any amounts due and owing hereunder.
I understand that the Pharmacy can provide for regular automatic payments from an established checking or savings account or to a credit card. If I elect an automated payment method, I will sign a separate authorization form, but understand that the terms arid conditions of this agreement will still apply.

Financial Responsible Party (please print)_____ Relation_____

Address_____ Phone Number _____

_____

_____ Email _____

AUTO PAY [ ] Card: _____ Exp__/___ Zip OR ACH Account _____ Routing #_____

Signature X_____ Date _____

(By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.)

Patient Information

Name_____ Date of Birth_____

Address_____ Home Phone_____

City_____ Social Security No._____

Physician(s) _____ Phone _____

Primary Insurance_____ Policy & Group #_____

Allergies

Please attach copies of front and back of patient's insurance cards.

Current Pharmacy and Location: _____

_____

Assignment of Benefits

I hereby request that payment of authorized insurance benefits be made on the Patient's or my behalf to the Pharmacy for medications, products and/or services furnished to the Patient or me. I authorize the Pharmacy to release any necessary or required personal health information to the Center for Medicare and Medicaid Services, any health insurance company, and/or their agents for the purpose of determining benefits or resolving any question regarding coverage.

AND

I hereby acknowledge that I have received a copy of the Pharmacy's Notice of Privacy Practices ((HIPPA), Routinely Purchased Items Notification, Equipment Warranty Information, Patient Rights & Responsibilities and CMS Medicare DMEPOS Supplier Standards (See reverse of this page) and understand each respective party's rights.

- **Fax to Connect Pharmaceuticals once completed: 866-922-8196**

_____ _____

Signature of Beneficiary (Patient or legal guardian *Date*