PHARMACY SERVICES AGREEMENT

Guardian Pharmacy of Wisconsin
11420 W. Theodore Trecker Way | West Allis, WI 53214
Phone: 414-727-5750
Fax: 414-727-5770

This is an agreement for pharmacy services with Guardian Pharmacy and

____ and ____.
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for Guardian Pharmacy agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Guardian Pharmacy, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by Guardian Pharmacy. Guardian Pharmacy does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that to provide me with the best treatment possible, Guardian Pharmacy may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize Guardian Pharmacy to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of Guardian Pharmacy supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by Guardian Pharmacy. If, for any reason, Guardian Pharmacy does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay Guardian Pharmacy directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account. Some commercial insurance plans do not cover Long Term Care (LTC) Services. If your plan does not cover these services, a fee for LTC services received may be reflected on your statement.
5. **PAYMENT OF BENEFITS.** I authorize Guardian Pharmacy to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to Guardian Pharmacy.
6. **ASSIGNMENT OF BENEFITS.** I authorize Guardian Pharmacy to request and collect on my behalf all public and private benefits due for the products and services supplied by Guardian Pharmacy. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Guardian Pharmacy.
7. **UNPAID INVOICES.** Guardian Pharmacy encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by Guardian Pharmacy related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Guardian Pharmacy reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to Guardian Pharmacy any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by Guardian Pharmacy. I also authorize all medical personnel to disclose information to Guardian Pharmacy relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to Guardian Pharmacy to use or disclose certain aspects of my health information to the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.com/hipaa-privacy-policy/]

I certify that I have received a copy of Guardian Pharmacy privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.com/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that Guardian Pharmacy is committed to protecting my health information. I certify that I have read and understand this agreement.

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of Guardian Pharmacy Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

PAYMENT INFORMATION

I certify that I have received a copy of Guardian Pharmacy payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

I UNDERSTAND AND HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES, THE NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES, AND THE PAYMENT INFORMATION DOCUMENTS AND AGREE TO BE BOUND BY THEM.

Signature [Resident or Responsible Party]**:** ____ **Date:** ___________________