Independent Living Pharmacy Enrollment Form

Please complete all information and print clearly. Any missing information may cause a delay in receipt of services and supplies. Fill in all fields below and return the completed form as requested below.

Resident Information

Assisted Living Facility Name	Account #
Resident First Name	Resident Last Name
☐ Male ☐ Female	DOB SSN
Allergies	Physician/Prescriber
Resident's Medication Insurance Plan	Insurance Contact Phone
Rx Insurance ID #	Rx Insurance Group #
Rx BIN	Rx PCN

Financially Responsible Party Information (please complete even if self)

First Name	Last Name	Phone
Email		
Street/Mailing Address		
City	State	Zip

Agreement to Pharmacy Services and Financial Responsibility

This agreement is entered into this day, between Independent Living Pharmacy ("Pharmacy") and the Resident and Responsible Party listed above who agree as follows:

1. The Pharmacy shall provide pharmacy services and supplies to the Resident on an open account and will provide the Responsible Party a listing of the medications supplied, and date of service.
2. The Resident and Responsible Party agree that they will be both individually and jointly responsible for paying to the Pharmacy any sums due for pharmacy services and supplies furnished to the Resident that are not reimbursed by outside sources, and the Responsible Party hereby guarantees that the pharmacy will be paid all sums due.
3. The Pharmacy will submit bills to the appropriate participating insurance plan or other reimbursement programs.
4. The Pharmacy will charge Resident or the Responsible Party for any co-payments and non-covered or un-reimbursed medications.
5. This Agreement shall bind the person or persons signed below. If signed by only the Responsible Party, it shall be binding on that party without regard to absence of the Resident's signature. If signed by only the Resident, the Resident shall be considered to be both the Resident and the Responsible Party for the purposes of this Agreement. Intending to be legally bound hereby, the Resident and Responsible Party have/has executed this Agreement providing for payment and guarantees of the sums due the Pharmacy for provision of pharmaceuticals and pharmacy services to the Resident on the date indicated below.
6. You consent to receive pharmacy services and supplies from Independent Living Pharmacy.

☐ **Yes!** I authorize Independent Living Pharmacy to bill my account for pharmacy services. I may discontinue this agreement at any time by contacting Independent Living Pharmacy.

☐ **No:** I choose to use another pharmacy provider. I understand this provider must comply with all applicable federal, state, and local laws and regulations pertaining to providing medications to a resident of an assisted living facility. This provider must have the capabilities of providing 24-hour and emergency service. While I choose to use another pharmacy as my provider, I authorize Independent Living Pharmacy to provide products or services to me in the event that my primary pharmacy cannot provide services in a timely manner as determined by the assisted living facility and agree with all terms and conditions listed above.

Resident or Responsible Party Signature

Date (mm/dd/year)

Families: Please return completed form to your assisted living facility contact.
Assisted Living Facility: Fax completed forms to the pharmacy.

If you have questions or need assistance, please contact your assisted living facility representative.