Patient Payment Agreement

I agree to provide credit/debit card information for Guardian Pharmacy to charge any outstanding balance due on a monthly basis. I voluntarily designate Guardian Pharmacy as my choice of provider of pharmacy services effective on the date indicated above (e.g., Discharge Date). I also request that payment of authorized Medicare B/or any other insurance benefits be made to Guardian Pharmacy for any services or supplies furnished to the above furnished resident by Guardian Pharmacy. I understand that I'm signing up for an autofill program of my prescription medications. I will notify Guardian Pharmacy in writing of my intent to cancel this agreement 30 days in advance. I understand that this packaging is non child proof.

I authorize release of medical or other information necessary to Guardian Pharmacy, the Social Security Administration, HCFA or it's other carriers, or other health insurance agencies that may apply for coverage of pharmacy items, or authorized benefits for services and supplies furnished on my behalf. I agree that when available and legally allowed, a generic product may be dispensed in an effort to contain costs. I agree to accept responsibility for and guarantee payment of all charges and for all services and supplies provided by Pharmacy Concepts, which are not covered by third party payors including Medicare and Medicaid. Any outstanding balances due after 30 days will be charged a finance charge of 1.5% monthly, which is an Annual Percentage Rate of 18%. I agree to pay all collection costs, court costs, reasonable attorney's fees, and taxes to recover any amount owed. This agreement is entered in Tarrant County, TX and payment is due and payable in same. In the event a dispute arises concerning this agreement, including payment, I agree that venue shall lie in Tarrant County, TX and that Texas law shall apply to the dispute. A "Drug Formulary" is a listing of drugs which will be paid for under certain state and insurance programs. On occasion, a physician may prescribe a medication which is not included on the third party payors Drug Formulary. Guardian Pharmacy will attempt to obtain special authorization to use the drug or attempt to have the Physician substitute the medication ordered with a suitable one from the Drug Formulary. If this is not possible, Guardian Pharmacy will supply non-formulary drugs and the payment will become my responsibility under applicable law.

I agree to the above terms and conditions as the responsible party. My signature authorizes any entity to release to Medicare, medical and non-medical information, including employment status, and whether the resident has insurance of any kind which is responsible to help pay for the services rendered. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient or resident is responsible only for the deductible, co-insurance, and non-covered services.

Print Patient Name : _____

_____ Date: _____

Signature (Patient or Responsible Party):

I agree to provide a credit/debit card, information for Guardian Pharmacy, LLC to charge any outstanding balance due on a monthly basis before medications are dispensed. Note: ACH Electronic Check available upon request

Credit / Debit Card

Name as it appears on Card: _____

Card #: _____ Expiration Date: _____SV Code: _____

Circle One: Debit/Credit Circle One: MC Visa Discover

Card Holders Signature: _____ Date: _____

Other Information:_____

(ie. Payment contact if different than patient)