Dear Sir or Madam:

It is our pleasure to welcome you to **Connecticut Pharmacy. Connecticut Pharmacy** is an independently owned pharmacy specifically devoted to servicing your pharmacy needs. Our services are being offered to you as a cost savings option.

A few of the Pharmacy Services available to you are:

- Competitive Prescription Pricing
- Can meet or beat OTC pricing from those providing similar pharmacy services
- Direct monthly charges to your credit card of choice
- Free Delivery, 7 days per week
- Acceptance of most Third Party Prescription Plans, including overrides on some mail order plans because of the specialty packaging we offer
- End-of-Year Recap Statement of all purchases, upon request
- Personal Care Products, including Depends, Ensure, vitamins, herbal supplements, and over-the-counter medications
- Specialized Prescription Compounding, Asthma and Diabetes Services
- Availability of our pharmacists to answer questions concerning your medications.

Please complete the attached documents and return to the Admissions Department, or mail to Connecticut Pharmacy at 664 Main Street, Norwalk, CT 06851. Also by fax 203-939-1789.

If you have any questions, please feel free to speak to the Admissions Coordinator or you can call the pharmacy at 1-203-939-1790 and ask for Customer Service.

Thank you and welcome to Connecticut Pharmacy.

Connecticut Pharmacy Management and Staff

Phone: 203-939-1790
Fax: 203-939-1789

REQUEST FOR PROVISION OF SERVICES

Acct. # _____

Facility: _____

House Hold: _____

Resident Name: _____ Date of Birth: _____

Social Security #: _____ Medicare #: _____

Resident Home Phone: _____

Physician's Name: _____ Phone# _____

Physician's Address: _____

Primary Prescription Insurance: _____

Cardholder Name: _____

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID# _____ Rx Group # _____ Rx BIN # _____

Rx PCN # _____ Insurance Company's Phone Number: _____

Please select one of the following statement options:

☐ Send statements to (billing address):

Mr./Mrs./Ms.: _____ Relationship to Resident: _____

Street: _____

City: _____ State: _____ Zip: _____

☐ Send statements via Email: _____

Preferred Contact Method:

☐ Phone: _____

☐ Text: _____ * By selecting this option, I agree to receive text messages. Message and data rates from my carrier may apply.

Please check below:

☐ I authorize Connecticut Pharmacy to keep my signature on file and to charge my Visa/MasterCard/American Express/Discover account for monthly medication statement charges. I understand that this form is valid through the expiration date of the card unless I cancel the authorization through written notice to Connecticut Pharmacy.

☐Visa ☐MasterCard ☐American Express ☐Discover Card

Credit Card #					–					–					–				

Expiration Date: Month _____ Year _____ CV _____

Cardholder (print) (as it appears on card): _____

Cardholder Signature: _____

Cardholder's Address: _____

City: _____ ST: _____ Zip: _____

Please read and sign: I understand that by signing this agreement, I indicate my wish to purchase medications and health care products/services from Connecticut Pharmacy. I (Resident) agree to be personally responsible for the charges of any medications and health care products/services provided by Connecticut Pharmacy to Resident. The responsible party is not personally responsible for charges unless the responsible party has power of attorney for estate, or has taken charge of managing any personal funds. The responsible party agrees to assist Connecticut Pharmacy to obtain payment if the Resident is unable.

_____ _____ _____

Date of Agreement Client Signature

_____ _____

Guarantor Signature Relationship

To ensure proper billing, please enclose copies (front & back) of Insurance cards

AL and RCH only: HIPAA Received: Y/N Date: _____ Resident initials _____

RESIDENT AGREEMENT

Resident's Name: _____

Indication of Medical Responsibility
I understand that the Resident is under the supervision and control of his/her attending physician. I understand also that his/her physician has prescribed the therapy/prescriptions as part of the resident's treatment. I understand that Connecticut Pharmacy does not include diagnosis, prescriptive or other functions typically performed by licensed physicians and that the Resident's physician is solely responsible for diagnosing and prescribing drugs and therapy for the Resident's condition and otherwise supervising and controlling the Resident's medical care.

Agreement to Pay
Our billing ends on the last day of the month. You will receive a statement around the 5th of the month. This statement will include a copy of your credit card receipt. If there is a change in payor source (i.e., a change to which credit card you would like to use or a change in your insurance coverage), please notify our Accounts Receivable Department at 203-939-1790 opt 4. Please feel free to call our Accounts Receivable Department if you have any questions.

Assignment of Benefits
I authorize the release of any medical/other information necessary to process claims. I also authorize payment of medical benefits to be made directly to Connecticut Pharmacy for services provided to the above stated Resident.

Release of Information
The undersigned authorizes the insurer(s) and any other third party payor who provides Resident with coverage to disclose to Connecticut Pharmacy. Any information regarding such coverage including but not limited to: (a) payment made by such insurer(s) or third party payor(s) to any of us, for therapy rendered to the Resident by Connecticut Pharmacy; and, (b) the scope and extent of coverage available from time to time. Resident authorizes all medical personnel to provide information to Connecticut Pharmacy concerning his/her medical history as it may relate to Resident's therapy.

The undersigned consents to the review of his/her records including medical records by any federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

The undersigned certifies that he/she has read the foregoing and received a copy as well as a copy of the Residents Rights and Responsibilities. The undersigned also certifies that he/she is the Resident *or is authorized by the Resident as the Resident's general agent to execute the above and accept its* terms. NOTE: A duplicate copy of this Agreement and Consent shall be considered the same as an original.

Resident signature:_____ Date:_____

Spouse/Guarantor/Guardian signature:_____ Date:_____

RESIDENT'S RIGHTS

A resident receiving medication and services from Connecticut Pharmacy has the right to:

1. Receive appropriate and professional quality services without discrimination based on race, creed, religion, sex, national origin, handicap, sexual preference or age.
2. Receive information necessary to provide for care. This information should include an explanation of all services and/or medications The Connecticut Pharmacy is to render and when and how such services/medications will be provided.
3. Timely service and response to reasonable inquiries.
4. Privacy and appropriate confidentiality of records, including the right to consent to the release of record to any individual not employed by Connecticut Pharmacy except for physicians or other medical personnel consulting on his/her medical condition or in the case of transfer to another health care facility, requirements of law, third party payment contracts, or requirements of federal, state or accrediting body or agency.
5. Be informed regarding charges and payments for services, including availability of third party coverage and reimbursement.
6. Examine records kept by Connecticut Pharmacy
7. Relating to him/her, unless medically contraindicated as documented and signed by his/her physician.

*** * RESIDENT'S COPY * ***