Dear Sir or Madam:

It is our pleasure to welcome you to Connecticut Pharmacy Wallingford LTC. Connecticut Pharmacy Wallingford LTC is an independently owned Connecticut 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
- Direct monthly charges to your credit card of choice
- Free Delivery, 7 days per week
- Acceptance of most Third Party Prescription Plans
- End-of-Year Recap Statement of all purchases, upon request
- Personal Care Products, including incontinence products, nutritional drinks 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
- Blood Pressure Screening by a pharmacist, followed by a review of medications for proper administration and drug interactions, per request

Please complete the attached documents and return pages 2 & 3 and 4 if applicable, to the Admissions Department, or mail to Connecticut Pharmacy Wallingford LTC at 10 Fairfield Boulevard, Unit 2C, and Wallingford, CT 06492. Also by fax: 203-815-1661 or email: arw@ctpharmacy.net

If you have any questions, please feel free to speak to the Admissions Coordinator or you can call the pharmacy at 1-203-691-9619 Ext. 423 or option #9. Please ask for Accounts Receivable.

Thank you and welcome to Connecticut Pharmacy Wallingford LTC.
Connecticut Pharmacy Wallingford LTC Management and Staff

REQUEST FOR PROVISION OF SERVICES

Acct. # _____

Facility: _____

Resident Name: _____ **Date of Birth:** _____

Social Security #: _____ **Medicare/HIC #:** _____

Resident Home Phone: _____

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

Primary Prescription Insurance: _____ **BIN#** _____

Cardholder Name: _____ **PCN#** _____

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

ID# _____ **Rx Group #** _____ **Plan #** _____

Insurance Company's Phone Number: _____

Physician's Name: _____ **Phone#** _____

Physician's Address: _____

Secondary Prescription Insurance: _____ **BIN#** _____

Cardholder Name: _____ **PCN#** _____

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

ID# _____ **Group #** _____ **Plan #** _____

Insurance Company's Phone Number: _____

Send statements to (billing address): _____

Mr./Mrs./Ms.: _____

Relationship to Resident: _____

Street: _____ **City:** _____

State: _____ **Zip:** _____ **Phone #:** _____

Please check one: (see next page if electronic checking is desired)

I authorize Connecticut Pharmacy Wallingford LTC 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 Wallingford LTC.

☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover Card**

Credit Card #					□					□					□				

Expiration Date: **Month** _____ **Year** _____ **CVV** _____

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 Wallingford LTC. I (Resident) agree to be personally responsible for the charges of any medications and health care products/services provided by Connecticut Pharmacy Wallingford LTC to Resident. The responsible party is not personally responsible for charges unless the responsible party has power of attorney for the estate, or has taken charge of managing any personal funds. The responsible party agrees to assist Connecticut Pharmacy Wallingford LTC to obtain payment if the Resident is unable.

_____	_____	_____
Date of Agreement	**Client Signature**	**Reason for not signing**
	_____	_____
	Guarantor Signature	**Relationship**

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

Insurance Information (continued)

(please check all that apply)

___No pharmacy insurance
___Private insurance with pharmacy benefits (copy of front and back of card)_

__Medicare Part A&B ID #_____ (copy of front and back of card)
___Medicare Part D (copy of front and back of card)
___CT Medicaid/Title 19 ID#_____(copy of front and back of card)
___Military ID #_____(copy of front and back of card)
Please circle if VA Benefits Tricare for Life ChampVA

ACH Authorization Form

Please provide the required information and return this Authorization Agreement if payment by electronic check is desired.

Customer/ Guarantor Signature_____

Customer/ Guarantor Name (please print):_____

Type of account (checking or savings):_____

Date:_____

PLEASE INCLUDE A VOIDED CHECK

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 also understand that his/her physician has prescribed the therapy/prescriptions as part of the resident's treatment. Per request we offer compliance packaging such as blister packs and MOT that are being dispensed in non-safety packaging. I understand that Connecticut Pharmacy Wallingford LTC 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 7th 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 203-691-9619 ext. 423 or option #9. Also by fax: 203-815-1661 or email: arw@ctpharmacy.net . 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 Wallingford LTC 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 residents with coverage to disclose to Connecticut Pharmacy Wallingford LTC. 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 Wallingford LTC; and, (b) the scope and extent of coverage available from time to time. Resident authorizes all medical personnel to provide information to Connecticut Pharmacy Wallingford LTC 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 Wallingford LTC 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 Connecticut Pharmacy Wallingford LTC 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 Wallingford LTC 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 Wallingford LTC**
7. **Relating to him/her, unless medically contraindicated as documented and signed by his/her physician.**

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