Omnicare
Pharmacy Services

Resident Move-In Record and Agreement

Community Name	ID #	Move-In Date	Pharmacy Name
Apartment/Unit #	Bed #	Customer ID #	

☐ **Check here if we are your primary pharmacy** ☐ **Check here if we are your emergency only pharmacy**

I. RESIDENT INFORMATION. Please verify all information is correct. ☐ Yes ☐ No
(Indicate corrections or missing information.)

First Name _____ Last Name _____ MI _____

Preferred Name/Nickname _____ Social Security # _____

Medicare (HICN)# _____ Date of Birth _____ Sex: ☐ M ☐ F

Physician's Name _____ Phone Number (___) _____

Resident is solely responsible for the financial and legal authorizations: ☐ Yes ☐ No
If NO, please list the Legal Representative below:

First Name _____ Last Name _____ Relationship to Resident _____

Address _____

City _____ State ___ Zip _____ Phone # (___) _____ ☐ Mobile ☐ Landline

A Legal Representative is a person who has been granted the authority in writing by either the Resident or a court of law to make medical and/or financial decisions on behalf of the Resident.

II. PRIMARY CONTACT & FINANCIALLY RESPONSIBLE PARTY INFORMATION

First Name _____ Last Name _____ Relationship to Resident _____

Address _____

City _____ State ___ Zip _____ Phone # (___) _____ ☐ Mobile ☐ Landline

Primary Contact is also Financially Responsible Party: ☐ Yes ☐ No
If NO, please list the Financially Responsible Party below:

First Name _____ Last Name _____ Relationship to Resident _____

Address _____

City _____ State ___ Zip _____ Phone # (___) _____ ☐ Mobile ☐ Landline

A Financially Responsible Party is a person, other than the Resident, who agrees to be responsible for payment of all amounts owed by the Resident for products and services provided to the Resident.

III. NON-COVERED MEDICATION

Please indicate the preferred method for handling medications not covered by insurance.

☐ Dispense all medications (Prescription and Over-the-Counter, whether covered by insurance or not)

☐ Dispense all covered medications and send a seven-day supply or smallest package size

☐ Only dispense prescription medications covered by insurance*

*Items not covered by insurance or awaiting automation will not be dispensed

IV. PAYMENT SOURCES FOR PHARMACY PRODUCTS AND SERVICES

Please verify all information is correct. ☐ **Yes** ☐ **No** **(Indicate corrections or missing information.)**

To assist in billing for medications and services provided to the patient while at this community, please check all pay sources that apply:

☐ **No prescription insurance** ☐ **Medicare-A** (Effective Date: ____ /____ /____) ☐ **Medicare-B** (Effective Date: ____ /____)

☐ **Medicare Part D** Plan Name _____ Member ID # _____ BIN/PCN _____

Group #_____ Phone Number (____) _____

☐ **Medicaid** #_____ State _____ Effective Date ____ /____ /____

☐ **Other Insurance** Name _____ Number _____ Phone Number (____) _____

☐ **Hospice Phone #** (____) _____ ☐ **Veteran Drug Benefit** or ☐ **Other** _____

Please describe "Other" and provide pharmacy with copies (FRONT and BACK) of ALL Drug Coverage Cards.

☐ **Authorization to contact via mobile/cellular device.**

By signing below, the Resident or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the terms described on the back of this document.

_____

Financially Responsible Party Name (Please Print) Signature Date

NOTE: If Resident has **personally signed**, it is not necessary to complete the information below. If the Resident is physically unable to sign, an authorized Representative may sign on his/her behalf, but must complete all information, including the Resident's medical reason for an inability to sign.

_____

Medical Reason for Patient's Inability to Sign

Omnicare
Pharmacy Services

Terms of Resident Move-In Record and Agreement

Resident Name **Community Name**

1. **Authorizations.** Omnicare, Inc. and its subsidiaries ("Omnicare") are authorized to provide the Resident all products and services prescribed or ordered by the Resident's Physician, or other legally-authorized prescriber, or by the Residence. The Resident requests the products provided by Omnicare be dispensed in containers that are not child resistant. The Resident requests that the Residence and/or Omnicare dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the Resident, according to Residence and pharmacy policy as allowed by professional standards and regulations.
2. **Legal Representative**. Legal Representatives will provide Omnicare with documentation establishing their legal authority to enter into this Agreement. If this Agreement is executed by the Legal Representative, the Legal Representative hereby affirms that s/he has the authority to enter into Agreements on the Resident's behalf.
3. **Health Care Representative.** Any individuals who are authorized to make health care decisions on behalf of the Resident will provide Omnicare with documentation establishing their legal authority to do so. The Health Care Representative will immediately notify Omnicare in writing of any change to the Resident's ability to make health care decisions independently.
4. **Financial Responsibility.** The Resident and the Financially Responsibly Party, if other than the Resident, shall each be individually and jointly liable for all charges for products and services provided by Omnicare and all fees and expenses described herein. Such services include all services authorized by the Resident or the Resident's Health Care Representative and may include services not covered by insurance or other third-party payers identified to Omnicare.
5. **Assignment of Benefits.** The Resident or Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Resident.
6. **Payment.** The Resident and Financially Responsible Party are responsible for paying all charges for products and services provided to the Resident by Omnicare which are not covered by insurance or other third-party payers identified to Omnicare. As a courtesy, Omnicare will submit claims to any insurance companies or other third-party payers listed above or of which Omnicare is subsequently notified in writing. Payment in full is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law will accrue on all delinquent accounts beginning on the day after the payment is due. The Resident or their Legal Representative and/or the Financially Responsible Party hereby authorize Omnicare to charge any credit card or bank account number identified above for any amounts owed.
7. **Fees and Expenses.** The Resident and Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this agreement, including without limitation, attorneys fees, court costs and expenses.
8. **Delinquent Payment.** The Resident or Legal Representative and Financially Responsible Party acknowledge that if the Resident and Financially Responsible Party are delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, do either or both of the following: (a) condition its continued provision of products and services to the Resident upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Resident. Such suspension or termination will in no way affect the Resident's or Financially Responsible Party's obligations to pay all amounts owed under this agreement, including costs of collection.
9. **Reliance and Consideration.** Omnicare is relying upon the Financially Responsible Party's agreements herein in determining to provide products and services to the Resident, and Omnicare's provision of products and services to the Resident constitutes good and adequate consideration for Financially Responsible Party's agreements contained in this agreement.
10. **Disclosure or Use of Resident Information for Treatment, Payment, and Healthcare Operations.** The Resident or Legal Representative hereby authorizes Omnicare, its employees, agents and sub-contractors to disclose to Medicare, Medicaid or any other third party payer any medical or other information needed for payment for all products and services provided by Omnicare to the Resident until payment has been made in full. The Resident or Legal Representative further authorizes Omnicare, its employees, agents and sub-contractors to use and disclose the Resident's medical and other information for the provision of products and services, for the business operations of Omnicare and for the review of Omnicare's services, including review by accrediting bodies or governmental agencies.
11. **Modification.** No modification or amendment of this agreement shall be effective unless agreed to in writing by a designated representative of Omnicare.
12. **Successors.** This agreement shall inure to the benefits of, and be binding upon, each party and its respective affiliates, successors and heirs, executors, administrators, insurers, underwriters, and affiliates of the parties.
13. **Supplier Standards.** The products and/or services provided to you by Omnicare and/or its corporate affiliates are subject to the supplier standards contained in the Federal

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regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.