



661 East Lane St. Shelbyville, TN 37160
 Telephone: 833-442-9716
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PHARMACEUTICALS PURCHASE AGREEMENT

Name of Resident:		Primary Care Physician:	
Resident's SSN:	Code Status:	Date of Birth:	
PLEASE SUPPLY A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD AND OR MEDICARE –PART-D AND MEDICARE CARD.			
PRESCRIPTION CARD/MEDICARE/MEDICARE ID #'S:			
Facility:	Room:	Unit:	Allergies:
<ul style="list-style-type: none"> • I understand that the use of Guardian MTPS as a provider of pharmaceuticals and other necessities is optional. • I understand that approved patient package inserts are available upon request. • I agree I have received a copy of Guardian MTPS's privacy practices and have had the opportunity to review the document and ask questions to assist my understanding of the resident's rights relative to the protection of the resident's health information. • I agree I have read the privacy practices for MTPS and certify that I am the resident, or authorized by the resident as the resident's general agent to execute the above conditions and accept its terms. • I understand and agree that all medications provided to me shall be delivered and received in non-child-resistant containers. <p>I agree to the following regarding purchases:</p> <ul style="list-style-type: none"> • I will pay the entire amount due for any purchases made within 15 days of the statement date shown on the monthly billing statement. • I agree in order for the account to remain active, the account must remain current, and I understand that no additional purchases will be allowed when it becomes 30 days past due. • I authorize facility personnel to make purchases on this account on behalf of the named resident. • I understand that this document must be on file in order of the pharmacy to provide any resident's medication and/or supply orders.. • I understand that payment is due upon receipt. 			
Responsible Party Name:			
Home Phone:	Cell Phone:	Other Phone:	
Email:			
Billing Address:			
City:	State:	Zip:	

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____