WELCOME!

We are Guardian Pharmacy Midsouth. Our partnership with communities and residents is significant. When you choose Guardian Pharmacy Midsouth you are getting a pharmacy that leverages modern technology with positive customer service principles. This allows us to deliver the best possible service and ensure you get the medications you need, when you need them, safely – and at the right price.

WHY USE GUARDIAN?

- **Cost Management** – Guardian coordinates directly with your physicians and third-party insurance providers to ensure minimal out-of-pocket medication costs
- **Billing Support** – Unlike a retail pharmacy, Guardian bills medications monthly, and their local billing staff is always ready to answer billing-related questions
- **Medicare Guidance** – The pharmacy helps you understand your Medicare Part D coverage and can offer one-on-one consultations during open enrollment
- **Clinical Support** – Guardian conducts ongoing medication reviews to ensure you're on the appropriate drug regimen
- **Compliance Packaging** – Easy-to-use packaging options, required by our community, organize your medications and minimize the risk of error
- **Timely Delivery** – Scheduled and emergency deliveries are available 24/7, eliminating trips to a local retail pharmacy
- **Integrated Technology –** Guardian's seamless integration of our community's electronic medication administration record (eMAR) system eliminates transcription errors and improves medication management

Guardian designs services to make sure you never have to worry about your medication needs. Our team of pharmacist, pharmacy technicians, billing specialist and delivery drivers work diligently to provide excellent customer services to everyone we have the privilege of servicing.

We start everyday thinking about those we are serving. Everyone at Guardian Pharmacy Midsouth strives to answer questions and communicate with our partners to provide outstanding outcomes. Our goal is to be a pharmacy partner that you can trust. Our team will always work hard to gain and keep your trust.

Thank you,

Curt Bicknell

President
Guardian Pharmacy Midsouth

RESIDENT ENROLLMENT FORM

☐ **Independent Living** ☐ **Assisted Living** ☐ **Memory Care**

COMMUNITY NAME _____ APT# _____

RESIDENT INFORMATION

RESIDENT NAME _____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# __-_____-_____ DOB _____/_____/_____ MEDICARE ID# _____ □ MALE □ FEMALE

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE _____

MEDICAL DIAGNOSIS _____ ALLERGIES _____

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN _____ CARDHOLDER ID# _____

RX GROUP# _____ RX BIN# _____ PCN# _____

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER _____

**A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE*

RESPONSIBLE PARTY INFORMATION

PRIMARY _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

ADDRESS* _____
[STREET] [CITY] [STATE] [ZIP CODE]

**MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS*

SECONDARY* _____ RELATIONSHIP TO RESIDENT _____
[FIRST] [LAST]

PHONE _____ □ HOME □ CELL EMAIL _____

**SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT*

RESIDENT ENROLLMENT FORM

PAYMENT INFORMATION

A valid credit card or ACH payment method is required to be kept on file to secure this account. Please fill out one of the boxes below based on your preferred payment method.

ACH / Checking Account

NAME OF BANK _____ NAME ON ACCOUNT_____

ROUTING NUMBER_____ ACCOUNT NUMBER _____

Credit Card

TYPE OF CARD (circle): VISA MASTERCARD AMERICAN EXPRESS DISCOVER

NAME ON CARD _____ CARD NUMBER _____

BILLING ADDRESS _____ EXPIRATION (MMYY) _____/_____

_____ SECURITY CODE _____

*VISA/MC/DISCOVER: 3 digits on back of card
*AMEX: 4 digits on front of card

Please select an option below and sign.

☐ *I wish to pay automatically by credit card each month – please enroll me in auto-pay.*

☐ *I wish to pay automatically by electronic check each month – please enroll me in auto-pay.*

☐ *I will mail in payment by check each month, pay monthly via online credit card portal, or call to pay by phone each month, promptly after receipt of Guardian's statement. **

*If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payments that remain delinquent may be turned over to collections and reported to credit reporting agencies.

RESIDENT OR RESPONSIBLE PARTY SIGNATURE _____

PHARMACY SERVICES AGREEMENT

Guardian Pharmacy Mid-south
7657 US-70, Bartlett, TN 38133
Phone: 855-313-2100 | FAX: 855-313-2101

This is an agreement for pharmacy services with Guardian Pharmacy Mid-south and

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for Guardian Pharmacy Mid-south's agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Guardian Pharmacy Mid-south, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by Guardian Pharmacy Mid-south. Guardian Pharmacy Mid-south does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, Guardian Pharmacy Mid-south may share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize Guardian Pharmacy Mid-south to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of Guardian Pharmacy Mid-south supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by Guardian Pharmacy Mid-south. If, for any reason, Guardian Pharmacy Mid-south does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay Guardian Pharmacy Mid-south directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account. Some commercial insurance plans do not cover Long Term Care (LTC) Services. If your plan does not cover these services, a fee for long term care services may be reflected on your statement.
5. **PAYMENT OF BENEFITS.** I authorize Guardian Pharmacy Mid-south to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to Guardian Pharmacy Mid-south.
6. **ASSIGNMENT OF BENEFITS.** I authorize Guardian Pharmacy Mid-south to request and collect on my behalf all public and private benefits due for the products and services supplied by Guardian Pharmacy Mid-south. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Guardian Pharmacy Mid-south.
7. **UNPAID INVOICES.** Guardian Pharmacy Mid-south encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by Guardian Pharmacy Mid-south related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Guardian Pharmacy Mid-south reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to Guardian Pharmacy Mid-south any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by Guardian Pharmacy Mid-south. I also authorize all medical personnel to disclose information to Guardian Pharmacy Mid-south relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to Guardian Pharmacy Mid-south to use or disclose certain aspects of my health information to: the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

NOTICE OF PRIVACY PRACTICES https://guardianpharmacy.com/hipaa-privacy-policy/

I certify that I have received a copy of Guardian Pharmacy Mid-south's privacy practices and have been given an opportunity to review the document and ask questions to assist my understanding of resident's rights relative to the protection of resident's health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at https://guardianpharmacy.com/hipaa-privacy-policy/. I further acknowledge that I am satisfied with the explanations provided to me and am confident that Guardian Pharmacy Mid-south is committed to protecting my health information. I certify that I have read and understand this agreement:

NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES

I certify that I have received a copy of Guardian Pharmacy Mid-south's Notice of Non-Discrimination and Complaint Procedures and have been given an opportunity to and did review the document including the free disabilities aids and language services available and was given an opportunity to ask questions to assist my understanding of it. I am confident I understand my rights and my options if I believe I have been discriminated against or guardian has failed to provide certain services.

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify that I have received a copy of Guardian Pharmacy Mid-south's Injury, infection, and emergency preparedness protocol and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

PAYMENT INFORMATION

I certify that I have received a copy of Guardian Pharmacy Mid-south's payment information and understand the available ways to pay my bills and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

I UNDERSTAND AND HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES, THE NOTICE OF NON-DISCRIMINATION AND COMPLAINT PROCEDURES, INJURY, INFECTION AND EMERGENCY PREPAREDNESS, AND THE PAYMENT INFORMATION DOCUMENTS AND AGREE TO BE BOUND BY THEM.

Signature [Resident or Responsible Party]**:** _____ **Date:** _____