## WELCOME TO THE PHARMILY

## BUBBLE PACKAGES

## ON TIME DELIVERIES

## CONSULTATION 24/7

# PHARMALIFE COMMUNITY PHARMACY

***Dear Faculty and Resident,***

It is with great pleasure that we extend a warm welcome to you as you join the Pharmalife family. We are thrilled to embark on this journey together, providing you and your residents with unparalleled pharmaceutical services and support.

At Pharmalife, we understand the importance of seamless and efficient processes, especially when it comes to billing and ensuring a positive experience for both facility and residents. Our dedicated billing team is committed to simplifying the billing process, minimizing administrative burden, and ensuring accurate and timely invoicing. With our streamlined approach, you can focus on what matters most – delivering exceptional care to your residents – while we take care of the rest.

***Professional, Empathetic Specialists***

Beyond billing, our focus on providing an exceptional experience extends to every aspect of our service delivery. From medication management to personalized consultations, our team of experienced professionals is here to cater to the unique needs of your facility and residents. We prioritize open communication, responsiveness, and collaboration to ensure that your expectations are not just met but exceeded.

As you settle into our partnership, we encourage you to explore the full range of services and resources available to you at Pharmalife Community Pharmacy. Our goal is to be more than just a pharmacy – we aim to be your trusted partner in enhancing the quality of care and overall experience for your facility and precious population of residents.

***Pharma Is Our Life***

Thank you for choosing Pharmalife Community Pharmacy as your pharmacy partner. We are honored to have the opportunity to serve you and residents, and we look forward to building a strong and successful relationship together.

*Sincerely,*

*Marcus Jackson, PharmD, MBA*

*Pharmacist in Charge, Pharmalife Community Pharmacy*

*Faculty - Please print pages 2 - 4 with resident and fax to 615-410-4791*

**PHARMACY SERVICES AGREEMENT**
**PHARMALIFE COMMUNITY PHARMACY**
**529 Brandies Cir**
**MURFREESBORO, TN 37128**
**P. 615-410-4790 F: 615-410-4791**

PHARMALIFE COMMUNITY PHARMACY
Est. 2021

## PURCHASE AGREEMENT

**This agreement is between Pharmalife Community Pharmacy and _____**
(Resident Full Name)

### Resident Identification and Prescription Insurance

Facility Name & Address: _____

Date of Birth: ____/ ____/ ____ Social Security Number: _____ Medicare Number: _____

Prescription Plan Name: _____

BIN # _____ PCN # _____ Relationship To Cardholder: ☐ SELF ☐ SPOUSE ☐ OTHER

*****Please send a photocopy of the insurance card (Front and Back) to fax 615-410-4791*****

### Responsible Party for Payment:

Name: _____ Phone: _____ Email: _____

Address: _____

**Choose Credit Card or Banking information required. Please fill out one below:**
Should you wish to provide the details below in a secure link, please request at the email: rx@pharmalifecp.com

| Credit Card Type (Circle) : VISA / MASTERCARD / AMEX / DISCOVER<br><br>Cardholder Name: _____<br><br>Billing Address & Zip Code:_____<br>_____<br><br>Card #:_____<br><br>Expiration: _____ Security Code: _____ | BANKING INFORMATION<br><br>Bank Name: _____<br><br>Name on Account:_____<br><br>Routing Number: _____<br><br>Bank Account Number: _____ |
|---|---|

Resident of Responsible Party Signature: _____ Date: _____

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**PLEASE SELECT FROM THE FOLLOWING PAYMENT OPTIONS BELOW**

☐ I am enrolling in automatic payments. I authorize Pharmalife Pharmacy to receive payment for charges not paid by my insurance company determined by invoice due date.

☐ I will submit monthly payments determined by the invoice due date. I authorize Pharmalife Pharmacy to bill the payment method provided if payment is not received by the invoice due date.

Please read the following statements carefully:

- The Resident/Responsible Party understands that the use of Pharmalife Pharmacy and the services provided by Pharmalife Pharmacy is optional.
- The Resident/Responsible Party understands and agrees that Pharmalife Pharmacy may make automated phone calls, emails, and text messages as reminders to pay bills and/or collect payment.
- The Resident/Responsible Party agrees that Pharmalife Pharmacy may bill the banking information or credit card listed above if payment is not received by the invoice due date.
- The Resident/Responsible Party understands that if payment is not received, Pharmalife Pharmacy may discontinue all services provided and may report the bill to credit reporting agencies.
- The Resident/Responsible understands that if payment is not received, a 1.5% per month may be charged on balances over 30 days past due.
- The Resident/Responsible Party understands that not all commercial insurance covers Long Term Care services. If your plan does not cover these services, the Resident/Responsible party agrees to pay the fee for Pharmalife services provided and will be itemized on your invoice.

Please initial to acknowledge the above statements: _____(Initial)

**Notice of Privacy Practices & Patient Bill of Rights**

_____(Initial) I certify that I have reviewed the Pharmalife Pharmacy Bill of Rights following www.pharmalifecp.com → Resources → Bill of Rights and was provided ample opportunity to ask questions.

_____(Initial) I certify that I have reviewed Pharmalife Pharmacy Notice of Privacy Practices following www.pharmalifecp.com → Resources → Notice of Privacy Practices and was provided ample opportunity to ask questions.

THE RESIDENT OR RESPONSIBLE PARTY SIGNATURE: _____ Date: _____

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**This is an agreement for pharmacy services with Pharmalife Community Pharmacy**

I agree to the following terms and conditions for pharmaceutical services:

A. **HIPAA AUTHORIZATION:**
B. **RELEASE OF INFORMATION:**
C. **MEDICAL RESPONSIBILITY:**
D. **PATIENT RESPONSIBILITY:**
E. **FACILITY INVOLVEMENT:**
F. **FINANCIAL RESPONSIBILITY:**
G. **PAYMENT:**
H. **UNPAID INVOICES:**
I. **WITHHOLD SERVICES:**

I have read and understand the above terms and conditions and agree to be bound by each condition specified.

_____ and _____

[RESIDENT] [RESPONSIBLE PARTY]