Mullaney's
A Guardian Pharmacy®

Resident Pharmacy Enrollment Form

* all required fields

Facility Name*

Room Number
if available

Delivery Address

Resident Information

Last Name
please print

First Name

Middle Initial

Date of Birth
MM/DD/YYYY

Phone Number

Gender

Home Street Address
for billing purpose

City

State

Zip Code

Social Security Number

Insurance Company and ID Number

Is Mullaney's the Resident's primary pharmacy?

☐ Yes ☐ No
if no. What is theit emergency pharmacy?

charges may apply if not our customer

Are the Resident's medications managed by community?

☐ Yes ☐ No
self administered

Mullaney's
A Guardian Pharmacy®

Resident Pharmacy Enrollment Form

* all required fields

Is the Resident responsible for all pharmacy services, including the bill and any other finances?

☐ Yes ☐ No
if no, please complete the next section below (Financially Responsible Party)

Financially Responsible Party

Only complete if there is a Responsible Party, other than the Resident, who agrees to be responsible for payment of all amounts owed by the Resident for prescription drug products and services provided to the Resident by Mullaney Pharmacy

Last Name

First Name

Email

Home Phone Number

Cell Phone Number

Billing Address

City

State

Zip Code

People involved in the Resident's health care

The following people are involved in the Resident's health care and have permission to manage the Resident's prescriptions.

Full Name

Phone Number

Check all that apply:

☐ Same as financially responsible party
☐ Legal Guardian by power of attorney
☐ Legal Guardian by court order
☐ Spouse
☐ Child
☐ Other

Acknowledgement
of Receipt of Privacy Practices

* all required fields

Under the Federal HIPAA Privacy Rule, we are required to give you our notice of Privacy Practices and make a good faith effort, before providing services, to get you:

Name of Patient

Facility or Organization

By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Mullaney Pharmacy and its affiliated entities.

Signature

Date

Patients. Parent, or Legal Represectative

Name

If signed by someone other than patient. Relationship to Patient

Inability to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

If the patient refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the patient's acknowledgement and the reasons why the acknowledgement was not obtained:

- Patient/Representative refused to sign
- Patient/Representative unable to sign
- Other (explain)

Signature

Date

Person who attempted to obtain acknowledgement

For Pharmacy use only:

- Entered into computer
- Processed for filing

Please fax this document to Mullaney's Pharmacy immediately.

Payment Sources for
Pharmacy Products and Services

Does the Resident have prescription insurance coverage ?

☐ Yes
If yes, please check all pay sources that apply:

☐ No

Medicare Part B

Effective Date

Medicare Part B Number

Hospice

Hospice Name

Phone Number

Medicare Part D or Rx Insurance (Commercial) Plan Name

Plan Name

ID Number

Group Number

BIN/PCN

Phone Number

Medicaid

Number

State

Date

Signature

By signing below, the Resident or Resident's Representative acknowledges and agrees as set forth below.

Resident Signature / Representative Signature*

Printed Name

Date

PHARMACY SERVICES AGREEMENT

MULLANEY'S A GUARDIAN PHARMACY
11930 Kemper Springs Dr. Cincinnati, OH 45240
513-587-6202 phone | 513-587-7650 fax

This is an agreement for pharmacy services with MULLANEY'S A GUARDIAN PHARMACY and

_____ and _____
[RESIDENT] [RESPONSIBLE PARTY]

In exchange for MULLANEY'S A GUARDIAN PHARMACY's agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize MULLANEY'S A GUARDIAN PHARMACY, 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 MULLANEY'S A GUARDIAN PHARMACY. MULLANEY'S A GUARDIAN PHARMACY 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, MULLANEY'S A GUARDIAN PHARMACY 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 PHARMACYOF NWFL 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 MULLANEY'S A GUARDIAN PHARMACY 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 MULLANEY'S A GUARDIAN PHARMACY. If, for any reason, MULLANEY'S A GUARDIAN PHARMACY 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 MULLANEY'S A GUARDIAN PHARMACY directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account.
5. **PAYMENT OF BENEFITS.** I authorize MULLANEY'S A GUARDIAN PHARMACY 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 MULLANEY'S A GUARDIAN PHARMACY.
6. **ASSIGNMENT OF BENEFITS.** I authorize MULLANEY'S A GUARDIAN PHARMACY to request and collect on my behalf all public and private benefits due for the products and services supplied by MULLANEY'S A GUARDIAN PHARMACY. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to MULLANEY'S A GUARDIAN PHARMACY.
7. **UNPAID INVOICES.** MULLANEY'S A GUARDIAN PHARMACY 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 MULLANEY'S A GUARDIAN PHARMACY related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** MULLANEY'S A GUARDIAN PHARMACY 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 MULLANEY'S A GUARDIAN PHARMACY 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 [PHARMACY NAME]. I also authorize all medical personnel to disclose information to MULLANEY'S A GUARDIAN PHARMACY relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to MULLANEY'S A GUARDIAN PHARMACY 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 [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of MULLANEY'S A GUARDIAN PHARMACY'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 [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that MULLANEY'S A GUARDIAN PHARMACY 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 MULLANEY'S A GUARDIAN PHARMACY'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.

MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item. I have been given the opportunity to and did examine the Medicare Capped rental and inexpensive or routinely purchased items notification and was given an opportunity to ask questions to assist my understanding of it.

INJURY, INFECTION AND EMERGENCY PREPAREDNESS

I certify that I have received a copy of MULLANEY'S A GUARDIAN PHARMACY'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 MULLANEY'S A GUARDIAN PHARMACY'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, THE MEDICARE CAPPED RENTAL & INEXPENSIVE OR ROUTINELY PURCHASED ITEMS, INJURY, INFECTION AND EMERGENCY PREPAREDNESS, AND THE PAYMENT INFORMATION DOCUMENTS AND AGREE TO BE BOUND BY THEM.

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