DANVILLE
LONG TERM CARE PHARMACY

439 Mill Street • Danville, PA 17821 • Tel: (570) 284-4667

Responsible Party Agreement

Personal Information:

Community Name: _____

Name of Resident: _____ Date of Birth: _____

Check One: ☐ Male ☐ Female Social Security Number: _____

Responsible Party Name: _____

Responsible Party Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Relationship to Resident: _____

Financial Information:

☐ Private Pay ☐ Private Insurance ☐ Medicaid ☐ Pending Medicaid -Applied _____

☐ Medicare D ☐ Medicare A/B ☐ PA PACE

You must provide a photocopy of front & back of patient's prescription insurance card

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree that community personnel are authorized to order, purchase and charge on behalf of the above resident.
- I agree to provide the pharmacy with a photocopy of the front and back of the insurance cards used for prescription coverage.
- I agree to notify the pharmacy of any future changes in prescription coverage
- I agree that any medication that has been discontinued or expired will be destroyed by the Facility and/or Pharmacy.
- I agree to pay all charges incurred by myself or the above named resident not paid for by third party payees, including Medicaid.
- I agree in order for the account to remain active, the account must remain current.
- I agree to pay all costs of collection including court costs and attorney's fees, if necessary, in order to collect any and all delinquent balances.

_____ _____

(Responsible Party/Guarantor) Signature

_____

Date