Financial Responsibility Form

Patient Name: _____ **Sex: M F** **DOB:** __ / __ /____

Facility/Home: _____ **Admission Date:** _____

Choice Pharmacy agrees to provide pharmaceutical services as ordered by the patient's medical team in accordance with the following:

- The party responsible shall pay Choice Pharmacy the co-pay amount (if any) based on the dollar amount given by the insurance. (Please note that co-pay amount with insurance is a price they define. Choice Pharmacy does not set the co-pay when billing medication with insurance)
- Any medications not covered by insurance that are prescribed by the physician will be dispensed at the best possible cash price from the pharmacy. The party responsible shall pay this amount.
- Any medications billed for within each month must be paid by the 21st of the following month.

Responsible Party Name: _____

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Phone #:** _____ **Alternate #:** _____

Relation to Patient:

The party responsible agrees to pay the amount due each month. While payments may be made with cash, money orders, and checks; a credit card is required on file as a back-up payment method. The card on file will be charged only if it is over 30 days past due or if the party agrees to let the pharmacy auto-charge the card every month for the bill.

Name on Card: _____ **Billing Zip Code:** _____

Credit Card #: _____ - _____ - _____ **EXP:** _____ / _____ **CVV:** _____

Would you like us to auto-bill the card? Yes or No If Yes, Which Day: _____

Mail monthly statement for payment to: Facility or Responsible Party (please circle)

By signing this document, I state I have read and agree to the Choice Pharmacy Financial Responsibility Agreement.

Print Name: _____

Signature: _____

Date: _____

Choice Pharmacy

401 S. Parsons Ave Suite C Brandon, FL 33511

P: 813-685-4707 F: 813-685-4722

Choice Pharmacy & Compounding Center

Acknowledgement of Pharmacy Services

Choice Pharmacy is dedicated to providing your medication(s) in a timely manner and ensuring that our pharmacists review all prescribed medications for potential conflicts, interactions and proper timing of administration. We, as your pharmacy provider, therefore prefer that all medications be filled through our pharmacy so as to provide the very highest level of service possible for our patients.

As a patient of Choice Pharmacy, you can rest assured that our team will provide the utmost level of care. If you have special requirements for your care, kindly let us know.

If your insurance is out of network, our pharmacy can offer you a cash price on your medication(s). We will call for authorization prior to filling.

By signing this document, you acknowledge that Choice Pharmacy will be your preferred pharmacy services provider and give us permission to transfer any necessary prescriptions, contact doctors and/or other health care providers for new prescriptions and otherwise take steps as is necessary to provide prompt and timely fulfillment of all provided pharmacy services.

Patient Name _____

Patient Signature _____

Responsible Party Signature _____

Date ____/____/_____