10929 Hwy 301 S., Suite 111 Statesboro, GA 30458
Telephone: 912-764-7839 / Toll Free: 877-736-2233
Fax: 912-489-1519/ Toll Free: 866-534-5566
Website: http://srcarerx.com/

PHARMACEUTICALS PURCHASE AGREEMENT

Name of Resident:	Primary Care Physician:	
Resident's SSN:	Date of Birth :	

PLEASE SUPPLY A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD AND OR MEDICARE –PART-D AND MEDICARE CARD.

PRESCRIPTION CARD/MEDICARE/MEDICARE ID #'S:

Facility:	Room:	Unit:
Previous Pharmacy:	Location:	

- I understand that the use of Guardian Pharmacy of South Georgia as a provider of pharmaceuticals and other necessities is optional.
- I understand that approved patient package inserts are available upon request.
- I agree I have received a copy of Guardian Pharmacy of South Georgia's privacy practices and have had the opportunity to review the document and ask questions to assist my understanding of the resident's rights relative to the protection of the resident's health information.
- I agree I have read the privacy practices for Guardian Pharmacy of South Georgia and certify that I am the resident, or authorized by the resident as the resident's general agent to execute the above conditions and accept its terms.

I agree to the following regarding purchases:

- I will pay the entire amount due for any purchases made within 15 days of the statement date shown on the monthly billing statement.
- I agree in order for the account to remain active, the account must remain current, and I understand that no additional purchases will be allowed when it becomes 30 days past due.
- I authorize facility personnel to make purchases on this account on behalf of the named resident.
- I understand that this document must be on file in order of the pharmacy to provide any resident's medication and/or supply orders.
- I understand that finance charges of 1.5% per month will accrue on balances over 30 days.

Responsible Party Name:

Home Phone:	Cell Phone:	Other Phone:

Email:

Billing Address:

City:	State:	Zip:

We accept checks and all major credit cards. If you would like to pay by credit card monthly, please complete the section below:

Credit Card #:	Type:	Exp. Date:

RESPONSIBLE PARTY SIGNATURE:_____DATE_____