Florida Medical Supply Pharmacy

5314-A Frank Hough Road

Panama City, Fl 32404

(800) 430-1857 FAX (850) 913-9352

RESIDENT INFORMATION AND RESPONSIBLE PARTY AGREEMENT

 **FACILITY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RESIDENT INFORMATION**: \_\_\_MALE\_\_\_FEMALE DATE: \_\_\_/\_\_\_/\_2020\_

Name of Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICAID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medicare#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** No Known Drug Allergies - Aspirin – Cipro- Codeine- Erythromycin- Keflex- Morphine-Motrin -Penicillin- Sulfa- Tetracycline-Valium- Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(circle)

**Responsible Party**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St:\_\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I UNDERSTAND, ACCEPT AND AGREE TO BE BOUND BY THE FOLLOWING TERMS AND CONDITIONS:

(State law may very with regard to the obligation of an agent)

1. I understand that the term “AGENT” in this form refers to one acting on behalf of the resident.
2. I agree that the personnel of the Care Facility are authorized to order/purchase medications, pharmaceutical supplies and service on behalf of the above named resident.
3. I agree to pay for all purchases and charges incurred by the above named resident not paid for by third party payers. This may include charges not covered by Medicaid, Medicare, or other insurance companies, where applicable.
4. I will pay the entire amount due on the billing statement by the 15th of every month and understand that a late charge may be added to the total outstanding balance for delinquency of 30 days or more.
5. I agree to pay for all collection procedures, including court costs and attorney’s fee, if necessary, in order to collect any and all delinquent balances.

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 AGENT’S SIGNATURE DATE

This form required before any services rendered! THANK YOU!!!

**Fax to 1-850-913-9352**