SPECTRUM PHARMACY
OF ARIZONA

# AGREEMENT FOR PHARMACY SERVICES

Spectrum Pharmacy of Arizona (hereafter referred to as PHARMACY) has an agreement with your facility to provide pharmaceuticals, drugs, and certain medical supplies in accordance with all State and Federal regulations. Residents have the right to purchase pharmaceuticals, drugs or certain medical supplies from the pharmacy provider of his/her choice.

**RESIDENT INFORMATION:**

Resident Name:_____ Facility Name:_____
Address:_____ City:_____ State:____ ZIP:_____
Primary Phone Number:_____ ☐ CELL ☐ HOME ☐ WORK ☐ OTHER
Secondary Phone Number:_____ ☐ CELL ☐ HOME ☐ WORK ☐ OTHER
Email:_____
Date of Birth: _____ SSN:_____ ☐ MALE ☐ FEMALE

**RESPONSIBLE PARTY INFORMATION:**

Responsible Party Name(s):_____
Address:_____ City:_____ State:____ ZIP:_____
Primary Phone Number:_____ ☐ CELL ☐ HOME ☐ WORK ☐ OTHER
Secondary Phone Number:_____ ☐ CELL ☐ HOME ☐ WORK ☐ OTHER
Email:_____ Relationship to Resident:_____

**HIPPA PRIVACY POLICY ACKNOWLEDGEMENT**

- ☐ I/We have received a copy of the HIPPA Privacy Policy for the PHARMACY
- ☐ PHARMACY may use and disclose my health information to my facility or to Responsible Party listed above

**PLEASE SELECT AN OPTION:**

- ☐ YES – I choose to use PHARMACY for all pharmaceuticals, drugs or certain medical supplies
- ☐ NO – I choose to use another pharmacy, but agree to pay the PHARMACY for emergency medications that my facility may order if my regular pharmacy cannot supply the medications in a timely manner.

**INSURANCE INFORMATION**

Primary Insurance:_____ Cardholder ID#:_____ Group #:_____
Secondary Insurance:_____ Cardholder ID#:_____ Group #:_____

## AGREEMENT OF FINANCIAL RESPONSIBILITY

BY SIGNATURE BELOW, I/WE DO HEREBY ACKNOWLEDGE AND ACCEPT RESPONSIBILITY TO PAY THE DEDUCTIBLE, CO-INSURANCE AND ANY OTHER BALANCES NOT PAID BY INSURANCE. As the responsible person(s), I/We do hereby assign and direct medical benefits payable for prescription services under any claim directly to Spectrum Pharmacy of Arizona. I/We authorize the PHARMACY to release any necessary medical information to the medical provider, or to the insurance companies involved in billing when requested. As the responsible party, I/We do hereby agree to pay all collections fees, attorney fees, service fees and court costs which may accrue, if payment for contracted services is not received and the account is referred to a collection agency. The PHARMACY agrees to provide sufficient notification of past due balances to prevent this from occurring. This agreement shall be in effect on a continuing basis until cancelled by the PHARMACY, the resident, or the responsible party. Written notice of such intent must be provided to all parties, and if applicable, the facility.

Resident Signature:_____ Date: _____
Responsible Party Signature:_____ Date: _____
Spectrum Pharmacy Representative:_____ Date: _____

Please fax completed form to (520) 296-0417 or email to info@spectrumpharmacyaz.com