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.

_____ _____

AGENT'S SIGNATURE DATE

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

Fax to 1-850-913-9352