PREMIER PHARMACY GROUP ADMISSION AUTHORIZATION FORM

Face Sheet/Patient Information sheet is attached: Yes ___ No ____

Patient Information (please print)

Patient Name: _____ Date of Birth: _____ Room #:_____

Male: ( ) Female: ( ) Social Security Number: _____ Move in Date:_____

Primary Physician:_____ Phone # :_____

Primary Prescription Insurance: _____ Phone #: _____

Name on Policy (if not patient): _____ Relationship: _____

RxID Number: _____ Rx Group Number:_____

BIN Number: _____ PCN: _____

PLEASE ATTACH A COPY OF ALL PRESCRIPTION INSURANCE CARDS - FRONT AND BACK

ALL CORRECT INSURANCE INFORMATION MUST BE PROVIDED OR RESPONSIBLE PARTY WILL BE BILLED FULL PRICE

Billing Information (to be completed by person responsible for payment):

Name:_____ Relationship:_____

Address:_____City:_____

State: _____Zip Code:_____ Personal Phone:_____

Work Phone:_____ Email:_____

Guarantee of Payment

After billing all given insurance, Responsible Party agrees to pay all co-pays, over-the-counter medications or non-covered charges.

I, the undersigned, authorize Premier Pharmacy Group, LLC access to the above-mentioned patients medical records for proper medication assessment. I guarantee payment in full for services rendered to the above-mentioned patient. Payment is due by the 15th of the month upon receipt of the monthly Statement. Premier Pharmacy Group,LLC reserves the right at any time to discontinue services to the patient for any account with a past due balance. There is a $40 service fee for all returned checks. The account will be assessed a penalty of 1.5% per month until paid in full. If the Pharmacy is required to pursue legal action to collect any balance due from me on behalf of the patient, I agree to pay reasonable attorney and collection agency fees and costs incurred in collecting any amounts due and owing hereunder. Automatic payments will be charged between the 10th - 15th of each month.

I understand that medications will be automatically refilled, dispensed and delivered. I agree that should the patient be discharged from the pharmacy it is my responsibility to notify Premier Pharmacy Group, or the patient will automatically be transferred to Premier Pharmacy Group's "Easy Med" home delivery system, for residents to conveniently receive their medications at home without interruption of services. I agree to be responsible for payment of all medications.

Responsible Party: _____ Date:_____

PREMIER PHARMACY GROUP

PAYMENT OPTIONS

Resident Name: _____ Facility Name:_____

Date of Birth :_____ Phone: _____ Email: _____

Premier Pharmacy Group, LLC will bill all applicable prescription insurance and send out a monthly itemized statement. After billing all appropriate agencies and insurances, we offer payment options for co-pays, over-the-counter medications, and non-covered charges.

Please choose one of the payment options below:

○ **Option 1: Online Payment**

Go online to our website **premierrxgroup.com** and click "Pay Bill" at the top of the page

○ **Option 2: Auto Withdrawal from Bank Account**

Please complete the form on the following page titled "Authorization for Auto withdrawal from Bank Account" to set up automatic payments from your checking or savings account.

○ **Option 3: Auto Withdrawal from Credit Card**

Please call our billing department at 719-457-6377, Option 5, or email **ppg.billing@rxppg.com**. A Team member will contact you for your credit card information.

I authorize Premier Pharmacy Group, LLC to charge my credit card on file monthly. This authorization will remain in effect until I cancel it. I may cancel this authorization at any time by calling 719.457.6377 or emailing **ppg.billing@rxppg.com**.

Name on Credit Card: _____ Exp. Date: _____ Billing Zip: _____

Signature of Card Holder: _____

Date: _____

○ **Option 4: Payment by Check**

Send a check to the Pharmacy by the due date to the address listed on your statement.

AUTHORIZATION FOR AUTO WITHDRAWAL FROM BANK ACCOUNT

Resident Name: _____ Date:_____

Patient Account Number : _____

By signing this authorization for auto withdrawal, I/we hereby authorize Premier Pharmacy Group, LLC to initiate debit entries via ACH from my/our bank account held at the financial institution named below. I/we hereby authorize Premier Pharmacy Group to debit the account between the 10th and 15th of every month reflecting the monthly amount due on my statement. ACH transactions will not occur on a Saturday, Sunday, or any national holiday recognized by the state of Colorado. I/we acknowledge that the amount of all debits executed pursuant to this authorization may vary, but each debit shall equal the amount due per statement.

ACH Instructions:

Name of Bank: _____ Name on Account: _____

Bank Address: _____ City _____ State_____ Zip: _____

I hereby authorize Premier Pharmacy Group to initiate debit entries to my: ( ) Checking Account ( ) Savings Account

Routing number: _____ Account Number: _____

This Authorization is to remain in full effect until Premier Pharmacy Group LLC has received written notification of its termination in such time and manner as to afford Premier Pharmacy Group, LLC and the appropriate bank a reasonable opportunity to act on such notification. I understand that if I fail to maintain a credit balance in the account to complete the ACH transaction a 3.5% of the amount due will be charged to reprocess the transaction.

A VOIDED CHECK IS REQUIRED

Please attach voided check here

I/We release Premier Pharmacy Group, LLC and its affiliates, agents, and representatives from all liability for their compliance with these instructions.

Name (printed): _____ Date: _____

Authorized Signature: _____ Title: _____