SUNWEST LTC PHARMACY

1300 N. 12th St, Suite 406
Phoenix, Arizona 85006
Tel: (602) 396-7330
Fax: (602) 688-8016

Patient Payment Guarantee Form

Patient Name: _____ Facility: _____

Sunwest LTC Pharmacy ("Pharmacy") agrees to provide to the resident all pharmaceutical services as needed.

Pharmacy will maintain a current drug profile on the resident, provide free delivery service and 24-hour emergency service. I hereby authorize these services to be rendered to the resident for whatever period of time the physician deems necessary.

In consideration for the agreement of the Pharmacy to provide medications and supplies to the above patient on an open account. (I/We) do hereby unconditionally guarantee payment to the Pharmacy for all medications and supplies purchased from the same and supplied to the above named patient while a resident of the above named facility.

(I/We) understand that all bills are due upon receipt. If not paid within 30 days of billing date, a 1.5% finance charge (18% per annum) will be assessed. (I/We) also agree to pay any legal fees and court costs incurred in the collection of this account.

I authorize any holder of medical and/or insurance information about me to disclose such information to the Pharmacy. I further authorize the Pharmacy to disclose any medical and/or insurance information concerning me in its possession: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payor who may be responsible for payment for Pharmacy services.

I authorize the Pharmacy to request on my behalf all public and private insurance benefits for products/services supplied to me by the Pharmacy. I further authorize payment for such products/services to be made directly to the pharmacy.

I will provide Sunwest LTC Pharmacy a copy of my insurance card (front and back) for billing purposes.

Insured's Name: _____

Insurance Company Name: _____ Group# _____

ID#: _____ Social Security #: _____

Insurance Company Phone #: _____ Date of Birth: _____

Insurance Company Address: _____

****Responsible Party Signature Required****

Responsible Party (print): _____

Responsible Party (sign): _____

Address: _____ State: _____ Zip Code: _____

Telephone Number: _____

O AMEX O Discover O MasterCard O Visa #: _____

Exp Date: _____ Security Code: _____

I authorize Sunwest LTC Pharmacy to use the above card for monthly pharmacy charges.

_____
Cardholder and/or Power of Attorney