Mercury Pharmacy Services, Inc.
22316 70th Ave W, Suite 5
Mountlake Terrace, WA 98043

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Pharmacy Agreement

REQUIRED: I want to use Mercury Pharmacy for ☐ **ALL OF MY MEDICATIONS** ☐ **EMERGENCIES ONLY**

Facility: _____*
Resident Name: _____* **Admit Date:** _____*
Date of Birth: _____* **Allergies:** _____*
Social Security #: _____* **Primary Physician** _____*

REQUIRED: Insurance for Prescription Coverage

Name of Plan: _____ Medicaid Y/N: _____

(Please provide copies of both front and back of card)

REQUIRED: Financially Responsible Party

Responsible Party: _____
Relationship: _____ POA Y/N _____
Billing Address: _____
City/State: _____ Zip: _____
Phone: _____ Email: _____

OR

Bill the Resident at the facility: ☐ Apt _____

Email bills only: ☐

E-mail: _____

AUTOPAY SIGN UP – Must be completed in full. (Optional):

I authorize Mercury Pharmacy to charge my debit/credit card each month.

Visa ☐ MasterCard ☐ American Express ☐ Discover ☐

Credit Card #: _____
Exp Date: _____
Name on Credit Card: _____
Security Code: _____ Zip Code: _____

I authorize Mercury Pharmacy to charge my bank account each month.

Routing #: _____
Account #: _____
Name on Acct:
_____

Mercury Pharmacy Services is dedicated to servicing the pharmacy needs of Long-Term Care Facilities. Our service includes specialized packaging for the residents, charge accounts, and deliveries. I understand that the community staff will be ordering and accepting delivery of medications on my behalf. This facility uses a unit dose system of drug packaging. It is necessary that all drugs in this facility conform to this system so that efficiency and accuracy are maintained per facility policies. Upon discharge, only those medications authorized by the resident's physician will be released to the resident or responsible party. Discontinued medications or medications remaining after the death or discharge of a resident will be disposed of per facility policies: Controlled drugs should be destroyed by the nursing staff as per licensing regulations. By signing this agreement, I accept all charges from Mercury Pharmacy and agree to pay them. For private pay residents, all pharmacy charges are **due on the date listed on our invoice.** All payments are to be made directly to Mercury Pharmacy Services. Accounts over 30 days delinquent are subject to bearing a monthly interest at a rate of 1.5%. Should the account be referred to collection the undersigned agrees to pay costs of collection, including reasonable attorney fees. Mercury Pharmacy Services reserves the right to discontinue providing medications to any account that is over one-hundred twenty (120) days delinquent. NSF check charges are $25.00 plus any collection costs. By signing this agreement, I authorize Mercury Pharmacy Services to bill Medicare or other insurances for the above patient if applicable. I also authorize Mercury Pharmacy Services to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable of related services. Blister packaging is not child proof. I request that the pharmacy fill my medication in non-childproof containers (i.e., Blister packs or easy open vials). By signing this agreement, the undersigned has acknowledged that they have received a copy of our privacy policies and has reviewed them. The undersigned accepts the terms of this agreement as stated above. I certify that I have the authority to sign this document for the resident named above.

Signature: _____ **Please print name:** _____ **Date:** _____