Patient Last Name:

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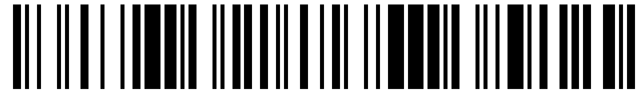

RESIDENT WELCOME INFORMATION

M Chest Institutional Pharmacy Group, LLC and all of its wholly and majority owned subsidiaries ("M Chest")

(Medicine Chest Institutional Pharmacy, LLC dba M Chest Pharmacy – Sulphur Springs; Houston Medicine Chest, LLC dba M Chest Pharmacy – Houston; Medicine Chest # 120, LLC dba M Chest Pharmacy - College Station; GHMED, LLC dba M Chest Pharmacy – Plano)

Dear Resident and/or Family Member:

Thank you for choosing M Chest Pharmacy as your pharmacy service provider! The entire team here knows what an important role pharmacy services provides in caring for you or your loved one and we hope to take a few minutes to explain some of the services to you as well. While you may be used to working with a retail pharmacy in the past, M Chest is very different from that experience, but yet very cost competitive as you will see. Here are a few of the services that are being provided and go above and beyond your typical retail pharmacy:

- 24 hours /7 days a week/ 365 days a year service
- Delivery of your medications to facility at no charge to you
- Staff in-servicing and education
- Knowledgeable Billing Department to assist you in all aspects of pharmacy drug coverage
- Emergency medication systems "in-house" for prompt medication access

In order to establish an account with M Chest Pharmacy, we will need the following information returned to us. Upon receipt of basic resident information and a copy of your prescription insurance cards and prior to receiving the Pharmaceuticals Purchase Agreement, M Chest Pharmacy will setup a temporary account for you that will be limited to $100 in total charges and these charges will be due upon receipt of your invoice at the end of each month. Once M Chest has received all of your signed forms, your account credit limit will be increased to $1,000 and you will be setup with 30 day payment terms. This means your monthly invoice will be due 30 days after the invoice date. During your stay, M Chest Pharmacy will not dispense individual medications ordered by the facility that will cost you, the Resident, more than $150 without getting the prior approval from you or your Legal Representative.

COPY & SEND **Resident Information**
Prescription Insurance Card(s)
Medicare and/or Medicaid Card(s)

SIGN & RETURN **Pharmaceuticals Purchase Agreement**

Fax completed forms and copies of insurance cards to the pharmacy servicing Facility – see www.mchest.com for pharmacy fax numbers.

Please feel free to contact us at 855-M CHEST1 (855-624-3781) to speak with any of our pharmacies or our billing office if you have any questions or concerns. In addition, if you feel we do not have current or accurate insurance information, our billing department will gladly accept the information over the phone, by contacting us at 855-M CHEST1 (855-624-3781).

We thank you again for the opportunity to serve you or your family member!

Sincerely,
M Chest Pharmacy

Patient Last Name:

____

RESIDENT INFORMATION

M Chest Institutional Pharmacy Group, LLC and all of its wholly and majority owned subsidiaries ("M Chest")

(Medicine Chest Institutional Pharmacy, LLC dba M Chest Pharmacy – Sulphur Springs; Houston Medicine Chest, LLC dba M Chest Pharmacy – Houston; Medicine Chest # 120, LLC dba M Chest Pharmacy - College Station; GHMED, LLC dba M Chest Pharmacy – Plano)

Resident's name: ____
(First) (Middle Initial) (Last)

Birth date: ____/_____/________Social Security #____________________________ ☐ Male ☐ Female

Facility Name:____

Primary Care Physician:______________________________Phone #: ______________________

Medical Diagnosis:____

Allergies: ____

Prescription Drug Insurance

It is very important for you to provide M Chest with the latest **prescription insurance** information to enable accurate billing.

You MUST complete below information in order for M Chest to file your insurance claims.

Prescription Insurance Plan:____

PCN:______________________________ Cardholder ID#________________________

Rx Group#:______________________________ Rx BIN#: ________________________

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Other ________________________

You MUST provide a copy of FRONT and BACK of the following two items or we will not be able to process your insurance:

☐ Prescription insurance card (Front and Back copied)

☐ Medicare and/or Medicaid Card

☐ Resident does not have prescription insurance and will be financially responsible for all charges from M Chest for pharmacy products or services.

______________________________ ______________________________

(Name of person completing form) (Relationship to Resident)

Patient Last Name:

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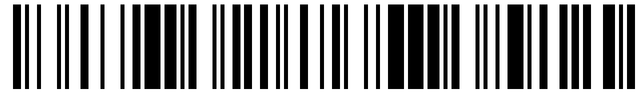


PHARMACEUTICALS PURCHASE AGREEMENT

M Chest Institutional Pharmacy Group, LLC and all of its wholly and majority owned subsidiaries ("M Chest")

(Medicine Chest Institutional Pharmacy, LLC dba M Chest Pharmacy – Sulphur Springs; Houston Medicine Chest, LLC dba M Chest Pharmacy – Houston; Medicine Chest # 120, LLC dba M Chest Pharmacy - College Station; GHMED, LLC dba M Chest Pharmacy – Plano)

This is an agreement for pharmacy services provided by any M Chest wholly or majority owned pharmacy

Resident Name (Please Print): ____

Resident's Date of Birth:__________________________ Soc. Sec. #: ______________________________

Resident is solely responsible for financial and legal authorizations: ☐ Yes ☐ No

If answer above is NO, please list Legal Representative below. A Legal Representative is a person who has been granted the authority in writing by either the Resident or a court of law to make medical and/or financial decisions on behalf of the Resident.

Legal Representative: ____

Address: ____

City:____________________________ State: _____________ Zip: ____________________________

Home Phone:____________________ Cell Phone: ____________________

Email: ____

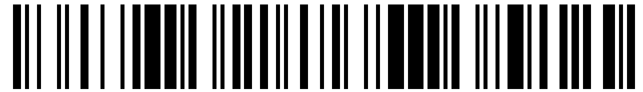
Relationship to Resident/ Resident: ☐Spouse ☐Child ☐Legal Dependent ☐POA

Each month an itemized bill for pharmacy services not covered by insurance will be sent to you. This bill is payable directly to M Chest upon receipt. If payment is not received by the next billing cycle, a 1.5% late fee (or a minimum $2.00 charge) will automatically be charged. M Chest also accepts payment by credit card (If you wish to pay by credit card, complete and return the separate Credit Card Authorization Form).

Request for Services: I understand that by signing this agreement I indicate my wish to purchase health care products or services from M Chest. I also understand that products provided by M Chest will be dispensed in containers that are not child resistant. I request that the facility and/or M Chest dispose of, or otherwise process, all unused and/or discontinued medications dispensed to me, according to the facility and pharmacy policy as allowed by professional standards and regulations.

Indication of Medical Responsibility: I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed the therapy, equipment and/ or supplies noted as part of my treatment. I understand M Chest services do not include diagnostic, prescriptive or other functions typically performed by a licensed physician and that my physician is solely responsible for diagnosing and prescribing drugs and therapy for my condition, and supervising and controlling my medical care.

Assignment of Benefits: I authorize M Chest to request on my behalf and collect all public and private insurance coverage benefits due for the products and services supplied to the Resident by M Chest. In the event payment for insurance benefits is made directly to any of the undersigned, the payee will endorse all checks for such payment to M



Chest. I hereby authorize M Chest to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions and authorize and direct my insurance carrier or its intermediaries to issue payment directly to M Chest. I hereby authorize M Chest to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

Release of Information: I authorize the insurer(s) and any other third party payor who provides the Resident with coverage to disclose to the M Chest any information regarding such coverage, including but not limited to:

a. payment made by such insurer(s) or third party payor(s) to any of us, for the therapy rendered to the M Chest; and

b. the scope and extent of coverage available from time to time. The Resident authorizes all medical personnel to provide information to M Chest concerning his/ her medical history if it relates to the Resident's therapy.

I consent to the review of my records including medical records by any federal, state or accrediting body or agency as required by the regulatory, licensing or accrediting body.

Consent to Use and Disclose Patient Information: The Patient or Legal Representative herby consents to M Chest, its employees, agents and sub-contractors disclosing to or receiving from the Medicare or Medicaid program or any other third party payer or their representatives or review organizations, as deemed necessary, patient information to determine benefits entitlement and to process payment claims for health care products and services provided by M Chest to the Patient. The Patient or Legal Representative further consents to M Chest, its employees, agents and sub-contractors using and disclosing the Patients medical and other information for the provision of products or services to the Patient, for the business operations of M Chest and for the review of M Chest's services, including review by accrediting bodies, surveyors, or governmental agencies.

Permission to Discuss Health Information with Other Individuals: In addition to the Legal Representative named above, I hereby grant M Chest permission to discuss my health information with the persons listed below who are involved in my care or payment for my care. *You may change or add to the individuals listed below at any time by contacting M Chest.*

1.__________________ 2.__________________ 3.__________________ 4.__________________

Privacy Notice: I certify that I have had an opportunity to review M Chest's Notice of Privacy Practices (available at www.mchest.com) and ask questions to assist me in understanding the rights relative to the protection of the above-named resident's health information. I am satisfied with the explanations provided to me and I am confident that M Chest is committed to protecting my health information

Requested Credit Limit: _____$1,000 or if less than $1,000 limit is desired, please enter amount below
_____$_______________

**M Chest will not dispense individual medications ordered by the facility that will cost the Resident more than $150 without getting the prior approval from the Resident or Legal Representative.

SIGNATURE PAGE FOLLOWS

Patient Last Name:

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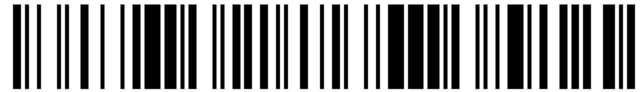

SIGNATURE PAGE – PHARMACEUTICALS PURCHASE AGREEMENT

In consideration of M Chest undertaking to supply the Resident with any products and services ordered by the Resident or on behalf of the Resident, the undersigned Resident, Legal Representative and/or Financially Responsible Party agrees that each is responsible to M Chest for payment to M Chest for all such products and services provided to the Resident, including the full amount of charges (plus any collection costs), if full payment is not made for any claims submitted to the Resident's insurance company. Resident agrees to transfer immediately to M Chest any payment made directly to Resident for services provided by M Chest on an assigned basis.

The undersigned certifies that he/she is the Resident, or is authorized by the Resident, as the Resident's general agent, to execute this Pharmaceutical Purchase Agreement and accept these terms. The undersigned certifies that the information furnished is true and correct and acknowledges that it is a crime to fill out this form with facts that are false or to leave out facts that are important. M Chest may contact Resident, Legal Representative or Financially Responsible Party in the future, via telephone or other means of communication in regard to Resident's account with M Chest.

Note: A duplicate copy of this Pharmaceutical Purchase Agreement shall be considered the same as the original.

Resident/Legal Representative Printed Name:______________________________

Resident/Legal Representative Signature:________________________________Date: __________________

Financially Responsible Party Signature:________________________________Date: __________________

Financially Responsible Party Name (Please Print): ____

Financially Responsible Party Phone #:_________________________ ☐Home # ☐Work # ☐Cell #

Billing Address: ____
Street

____ ________ ____________
City State Zip Code

Billing E-Mail Address for Financially Responsible Party: ______________________________________

A Financially Responsible Party is a person, other than the Resident, who agrees to be responsible for payment of all charges for products and services provided to Resident.