



## 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)*

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. M Chest is unique from ordinary retail pharmacies, yet very cost competitive. A few of the services that we provide above and beyond your typical retail pharmacy are:

- 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

M Chest will set up an account with 30 day terms, meaning payment will be due 30 days after the invoice date. During your stay, M Chest Pharmacy will not dispense individual medications ordered by the facility costing you, the Resident, more than \$150 without getting the prior approval from you or your Legal Representative.

COPY & SEND     **Resident Information (pg 4)**  
**Prescription Insurance Card(s) and Medicare and/or Medicaid Card(s) if applicable**

SIGN & RETURN   **Pharmaceuticals Purchase Agreement (pg 5)**

Fax completed forms and copies of insurance cards to the pharmacy servicing Facility – see [www.mchest.com](http://www.mchest.com) (select **Contacts** then **Locations** dropdown for pharmacy fax numbers) or mail to the following address:

**M Chest Pharmacy**  
**PO Box 6397**  
**Tyler, TX 75711**

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), Option 5.

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

Sincerely,  
M Chest Pharmacy

## PHARMACEUTICALS PURCHASE AGREEMENT

### **M Chest Institutional Pharmacy Group, LLC and all of its wholly and majority owned subsidiaries (“M Chest”)**

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This is an agreement for pharmacy services provided by any M Chest wholly or majority owned pharmacy. 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. If payment is not received within the 30 day terms, a 1.5% late fee (or a minimum \$2.00 charge) may be charged. M Chest also accepts payment by phone or online at the web address printed on your invoice. You can opt to create an account online to set up auto payments via credit card and/or receive emailed invoices.

**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, and for the cost of any pharmacy products and services that are not covered by my insurance, including any cost of collection or legal fee incurred to collect these balances. I understand that it is my responsibility to notify M Chest of any change in my insurance. I further understand that this assignment of benefits will remain in effect until revoked by me (or my legally authorized representative) in writing.

**Consent to Use and Disclose Patient Information:** The Patient or Legal Representative hereby 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 payor 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.

**Privacy Notice:** I certify that I have had an opportunity to review M Chest's Notice of Privacy Practices (available at [www.mchest.com](http://www.mchest.com)) and ask questions to assist me in understanding the rights relative to the protection of the below-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.

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 or legal representative 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.

Patient Last Name: \_\_\_\_\_



Admin Agreement

**RESIDENT INFORMATION**

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Resident’s name: \_\_\_\_\_  
(First) (Middle Initial) (Last)

Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security # \_\_\_\_\_  Male  Female

Facility Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Prescription Drug Insurance**

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

**Please provide a copy of the following (if applicable):**

Prescription insurance card (Front and Back)

Medicare and/or Medicaid Card (Front and Back)

**If no insurance:**

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

\*\*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.

**Requested Credit Limit:** \_\_\_\_\_ \$1,000 or if less than \$1,000 limit is desired, please enter amount below  
\_\_\_\_\_ \$ \_\_\_\_\_

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: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Financial POA  Yes  No

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_



Admn Agrmt

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**SIGNATURE PAGE – PHARMACEUTICALS PURCHASE AGREEMENT**

**Resident** Name (Print): \_\_\_\_\_

**Financially Responsible Party** Name (Print):  
(If other than self) \_\_\_\_\_

Financially Responsible Party Phone #: \_\_\_\_\_  Home #  Work #  Cell #

Financially Responsible Party Billing Address:

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail Address for Financially Responsible Party: \_\_\_\_\_

**Residents Signature:**  
(If own Responsible Party) \_\_\_\_\_

**Financially Responsible Party Signature:**  
(Responsible for Resident) \_\_\_\_\_

By signing above, I am agreeing to the terms and conditions of this contact. I also understand that I am giving consent to share PHI with anyone that I list in the next section, **Permission to Discuss Health with Other Individuals**.

**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 at [compliance@mchest.com](mailto:compliance@mchest.com).*

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

*Only return pages 4 and 5 along with insurance cards*