

Moye's Long Term Care Pharmacy
106A Rock Quarry Road
Stockbridge, GA. 30281
(770)507-1559
(770)507-1011

Resident's Information

Resident's Name: _____ Move-in Date: ___/___/___

Name of Assisted Living Home: _____ Room # _____

Phone Number: _____ Date of birth: ___/___/___

List of Drug Allergies (ie. Penicillin, Aspirin, etc..) : _____

List of Other Known Allergies (ie. Iodine, Seafood, etc..) : _____

Primary Physician's Information

Physician's Name: _____

Physician's Address: _____

Office Phone Number: _____

Pharmacy Insurance Information (PLEASE SEND COPY OF CARD(S) FRONT & BACK)

Name of Insurance: _____

Card ID#: _____ Group#: _____

Insured's Name: _____ Ins. Phone #: _____

Medicare #: _____ Social Security #: _____

Do you have mail order pharmacy coverage? Yes ___ No ___

If yes, do you plan to use the mail order pharmacy and have Moye's repackaging? Yes ___ No ___

(For Office Use Only)

___ Medication Management

___ Self-medicates

*Medications need to start on ___/___/___ at _____ am ___ pm ___

Type of Diet _____

Diagnosis: _____

Financial Information

Please enclose a copy of any power of attorney documents and copy of Driver's License

Power of Attorney/Grantor Information:

Name: _____ Relationship to Resident: _____
 Address: _____ Home Phone #: _____
 _____ Work Phone#: _____
 Date of Birth: _____ Driver's License No: _____ State _____
 Name of Nearest Relative (Not Living with You) _____
 Relationship: _____ Phone#: _____

Pharmacy Financial Agreement

We both understand that Moye's Long Term Care Pharmacy will provide medications and other supplies requested by the physician &/or assisted living facility personnel. The responsible party will be accountable for payment of these items ordered. Once medications have been delivered to the facility, medications may not be returned for a credit. Also, it is the facility and the guarantor responsibility to notify Moye's Pharmacy of any change in the resident's status at the facility, such as in the hospital, moved out, or deceased. Moye's Pharmacy must be notified of any status change within 24 hours. If Moye's has not been notified of a status change & medications are delivered, the resident may be subject to a \$50.00 restocking fee.

Moye's Pharmacy's monthly billing cycle is every thirty (30) days. I understand payment is due within fifteen (15) days of my receipt of the statement. I also understand that if I fail to pay for any prescription medication when due, I will be charged interest on all monies due at the rate of 18% per month until paid, but in no event more than the maximum rate permitted by law. Whenever any payment is not made by me when due hereunder, I agree to pay to Moye's Long Term Care Pharmacy an administrative charge to offset Moye's Long Term Care Pharmacy's collection expenses in an amount calculated at the rate of ten cents per one dollar for each such delayed payment; or fifteen dollars (\$15.00), whichever is higher. Such an amount shall be payable in addition to all amounts payable by me as a result of the collection efforts of Moye's Long Term Care Pharmacy to collect any amounts overdue.

Moye's Pharmacy charges a one time a month \$25.00 service fee. Any medications that are deemed as an emergency order & must be delivered after a scheduled delivery may be subject to a \$10.00 delivery fee.

We hereby authorize Moye's Pharmacy to obtain any credit information concerning the date herein, and to retain this information together with this statement. I hereby certify that the above information is correct and complete. We understand all the terms and conditions of this agreement.

We represent that if the signature of a responsible party below is that of a corporation, the party signing for the corporate entity has the authority to do so.

We as the resident and responsible party signed below, consent to the personal jurisdiction of the courts of the State of Georgia and the venue of Henry County, Georgia with respect to any action arising out of any agreement, guarantee, settlement agreement, promissory note, or other accommodation or agreement with Moye's Long Term Care Pharmacy. This means that any legal action filed against me and/or any guarantor or responsible party may be filed in the Superior Court of Henry County and that we may be required to defend and litigate any such action in Henry County, Georgia. We also agree that service of process by certified mail, return receipt requested, shall be deemed the equivalent of obtaining service of process and personal service in such action. Further, to the extent permitted by law, we waive trial by jury in any action and further waive any and all rights and remedies we may have under the Uniform Commercial Code as codified in the State of Georgia.

This agreement constitutes the entire agreement between the parties, superseding all previous proposals, oral or written. No representation or statement not contained on the original of this agreement shall be binding as a warranty or otherwise, nor shall this agreement be modified or amended except in writing, signed by the parties hereto. We also expressly disclaim having relied upon any representation or statement concerning the medications received from Moye's Long Term Care Pharmacy.

Responsible Party Signature	Date
Witness Signature	Date
Resident's Signature/Responsible Party	Date
Witness Signature	Date

Guaranty

I guarantee that the resident will pay all payments and other sums due under this financial agreement when due, and that the resident will perform all other obligations as required by this agreement. I also agree that Moye's Long Term Care Pharmacy may make other arrangements with the resident, and I will still be responsible for the resident's payments and obligations under the agreement as amended. If the resident defaults under this agreement, I agree to immediately pay all amounts due without notice from Moye's Long Term Care Pharmacy of the resident's default, plus any attorney's fees and other cost. I agree that this guaranty continues until all payments under this financial agreement have been paid in full, and that the above paragraph regarding jurisdiction and governing law shall apply to me.

Responsible Party's Signature

Date

Witness Signature

Date

List of Current Medications

****Please include Over-The-Counter Medications and Prescriptions****

Resident's Name: _____

Name of Medication	Strength	Amount per Dose	Frequency	Administration Times	Name of Physician

Physicians Name:_____ Phone#:_____

Physicians Name:_____ Phone#:_____

Physicians Name:_____ Phone#:_____

****If necessary we may need to call & transfer prescriptions from current pharmacy in order to fill the prescriptions. Please provide the following information:**

Name of Current Pharmacy: _____

Pharmacy's Address: _____

Pharmacy's Phone Number: _____

 Additional Comments:

Moye's Long Term Care
Non-Child Resistant Waiver

Resident's Name: _____

I have requested that my medication and all subsequent prescriptions be packaged in a non-child resistant package. I understand these packages are not child resistant and I will ensure the medications &/or packages will be kept out of reach of children.

If a child accidentally consumes any prescription drug, I will immediately notify poison control, the child's pediatrician, &/or emergency medical system.

I understand that I have the right to request at any time for my medications to be packaged in a traditional child-resistant container by notifying the pharmacist at (770) 507-1559.

Resident's Signature

Date

Resident's Responsible Person's Signature

Date

Moye's Employee's Signature

Date

Moye's Long Term Care Pharmacy
Mail Order Pharmacy Re-packaging Waiver of Liability
Revised 07/18/07

Residents Name: _____

Long Term Care Facility _____

I understand that I am requesting Moye's Pharmacy to re-package my medications filled at another pharmacy from its original container into a blister pack required by the long term care facility. I realize Moye's Pharmacy is not providing depiction of what medication is being dispensed or its accuracy from the other pharmacy. I hold Moye's Pharmacy harmless and take full reliability. I agree to pay a monthly packaging fee of \$15.00 for each multi-dose blister pack or \$4.00 per prescription for each unit dose blister pack. I also agree to be responsible for ordering and supplying all medications to be re-packaged. All medications needing to be re-packaged should be sent to Moye's five (5) business days prior to the start of the next cycle. I understand Moye's Pharmacy will give one courtesy call to notify when medications are insufficient to fill a complete cycle. If any of the medications are short 5 business days before the cycle is due, then Moye's will fill from the pharmacy stock the quantity needed to complete the cycle. I understand I will be charged for the cost of any medications filled from the pharmacy stock, in addition to the re-packaging fee.

I also understand that Moye's may only re-package my medications using the directions on the original bottle's label from another pharmacy. If the doctor decides to make a change in directions, I must arrange for the mail order pharmacy to be notified by the doctor and Moye's must be sent a new mail order bottle with a label showing the correct directions. I may arrange for the bottle showing the old directions to be sent to the home to be used until the new label arrives. It will be at the long term care facility's discretion as to dispense from the bottle or not.

I, also, understand Moye's Pharmacy will not re-repackage any medications that are over-the-counter (OTC), medications dispensed from non-registered pharmacy, medications that are liquid or bulk, or any samples from a drug manufacturer or doctor's office. If a resident needs any OTC medications, they can be purchased one cycle at a time directly through Moye's, but will not incur a re-packaging fee.

I understand and agree to all terms.

Resident's Signature

Date

Witness Signature

Date

Responsible Party's Signature

Date

Contact person to call when medications are insufficient

Phone Number

Based on above selection _____ (insert either resident, Responsible Party or Dogwood Forest) is responsible for initial acquisition and refilling of prescribed medications as long as the Residency Agreement is in effect.

Community Representative Signature

Resident or Responsible Party Signature

Title

Title

Date

Date