Parkway Pharmacy

23350 Mercantile Rd. Beachwood OH 44122

216-378-9894 (Phone) 216-595-2898 (Fax)

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FORM

RESIDENT INFORMATION

Last Name:	First Name:	Middle Initial:
Social Security #	DOB:	Gender: □ Male □ Female
Phone #		
Facility Name:	Resident's Room Number:	

FINANCIAL POA/FINANCIAL RESPONSIBILITY INFORMATION (*Responsible Party for Billing*)

Last Name:	First Name:	
****Address where bills are to be mailed****		
Address:	Apt/Suite#:	
City:	State:	Zip:
Phone# (Home):	(Cell):	(Work):

I, Financial POA, am responsible for payment of all prescription copays and over-the-counter medications and items filled on behalf of above named resident/patient. I understand that if above named patient applies for OH Medicaid or upon patient's death, I am responsible for payment of any and all prescriptions filled prior to this occurrence.

→**Signature (REQUIRED)**_____ **Date:**_____

Relationship To Resident:_____

MEDICARE/PRESCRIPTION INSURANCE INFORMATION:

***Please provide copies of all insurance cards (front/back) This information is required to fill prescriptions**

Is The Above Resident:

On Hospice? □ YES or □ NO If yes, indicate Hospice Organization:
On OH Medicaid? □ YES or □ NO If yes, indicate OH Med Billing #
Medicare Part B? □ YES or □ NO

[OVER] SEE REVERSE SIDE

Medicare Assignment of Benefits and Release of Information Lifetime Authorization

Authorization. Parkway hereby is authorized to provide me with all medications, pharmaceutical supplies and services that I may need.

Payment. I am responsible for the payment when due for all medicines, pharmaceutical supplies and services provided to me by Parkway Pharmacy. Finance charges will apply to any past due balances.

A $10.00 annual statement fee will be added if an email address is not provided as the primary method of monthly statement delivery.

All medications in multi-dose packaging are non-refundable and non-returnable – credit will not be issued.

Records. I hereby authorize Parkway to submit to any HMO, PPO, Insurance provider or other third-party payer any of my medical and financial records, which Parkway determines is necessary or desirable to obtain payment for any amount owing by me to Parkway.

Further Assurances. I hereby agree to execute upon Parkway's request any other documents which Parkway may request to further evidence any amounts owing by me to Parkway (including, without limitation, one or more promissory notes) and to provide collateral to secure the payment of such amounts.

Termination of Service. I acknowledge and agree that Parkway has the right to suspend or terminate service if my account is delinquent.

Fees and Expenses. I also will pay all costs and expenses incurred by Parkway in the enforcement of its rights under this Agreement including, without limitation, attorney's fees, court costs and expenses. "I request that payment of authorized Medicare and/or Private Insurance/Medigap benefits to be made to Parkway on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services."

→Please initial: _____ I acknowledge I have read the Parkway Pharmacy Notice of Information Practices (HIPAA)

Access document via website at: parkwaypharmacy.net

Open the Links tab and refer to the Parkway HIPAA Notice

Hardcopy Available Upon Request

THANK YOU & WELCOME TO PARKWAY PHARMACY!

[OVER] SEE REVERSE SIDE