Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
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Do not send anything that cost money Authorization Form

Patient Name:_____ ***Patient D.O.B.:***_____

I authorize Ready Meds Pharmacy (referred to in this agreement as "The Pharmacy") to provide medications and associated products and services to the above-named patient (referred to in this agreement as "The Patient"). I certify that I have the legal authority to sign this agreement on behalf of said The Patient. If I disagree with any medication, product or service directed by the facility or an attending physician, I will contact them and resolve the issue(s) and ask them to provide different written directions to The Pharmacy. I acknowledge and agree that The Pharmacy will provide medications, products and/or services based upon the most current written direction received.

For patients receiving benefits from an insurance company (referred to in this agreement as a Pharmacy Benefits Manager "PBM"), I am aware that The Pharmacy will bill the PBM for all medications, products and services covered by the PBM. I understand that by signing this agreement I will direct The Pharmacy not to send any medications, products, and services which will result in The Patient having to pay out of pocket expenses.

I understand and agree to the following:

- The Pharmacy will not send any items, medications, products and/or services not covered by insurance.
- The Pharmacy will not send any items, medications, products and/or services covered by insurance with copays.
- The Pharmacy will not call for permission to send items, medications, products and/or services that cost money.
- It is your responsibility to coordinate with the facility to supply items, medications, products and/or services that cost money.
- If an item, medications, products and/or services that cost money is sent, payment is required immediately.
- If an item, medications, products and/or services that cost money is sent monthly, a new form (autopay or deposit) is required.
- Medications furnished to The Patient are not packaged in child- proof containers.
- The facility personnel or caregivers are authorized to order products and services on behalf of The Patient.
- To pay all charges incurred by The Patient that are not paid for by their PBM, including Medicare and Medicaid.
- Medications that are delivered and subsequently discontinued or modified by The Patient's physician or otherwise not used by The Patient for any reason cannot be returned for credit. I understand that all medications, once delivered are not returnable per WAC 246-945-485, and I will be responsible for the full amount due.
- Statements printed at the beginning of the month are for products and services that were rendered the previous billing cycle, therefore should The Patient moves, leaves The Pharmacy's service, or passes away I am still obligated to pay the final balance. I agree to pay the entire amount due before the statement due date unless prior arrangements were made with The Pharmacy's billing department.
- To notify The Pharmacy immediately if The Patient's PBM changes.
- To notify The Pharmacy immediately if The Patient passes away, hospitalize, or relocates to another location.
- Before a full profile transfer to another pharmacy can occur, I must pay down The Patient's account to zero.
- If full payments are not received by the end of the month, I agree to pay a finance charge of 2.00% per month or a minimum service charge of $25.00 whichever is greater on the leftover balance.
- If no payment or partial payment were received for the previous month, The Pharmacy may reserve the rights to refuse services for The Patient until balance has been paid off.
- If my account becomes 90 or more days delinquent, The Pharmacy will freeze The Patient's account. No more products or services will be rendered until the balance has been paid off.
- To pay all costs of collection, including court costs and attorney fees, for all delinquent balances. There will be a closing fee of 50% of the final balance upon closing of the account.

Assignment of Benefits

I hereby request that payment of authorized insurance benefits be made on The Patient's or my behalf to The Pharmacy for medications, products and/or services furnished to The Patient. I authorize The Pharmacy to release any necessary or required personal health information to the Center for Medicare and Medicaid Services, any health insurance company, and/or their agents for the purpose of determining benefits or resolving any question regarding coverage ***AND*** I hereby acknowledge that I have received a copy of The Pharmacy's Notice of Privacy Practices (HIPPA), Patient Rights & Responsibilities and CMS Medicare DMEPOS Supplier Standards and understand each respective party's rights.

Responsible Party Print Name:	Relationship:	
Billing Address:	Email/Fax:	
Responsible Party Signature:	Phone Num:	Date:

(By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.)