austindrugs

To Whom It May Concern:

We thank you for allowing us to service your family and loved ones. As a new client to our pharmacy we ask that you fill out a Patient Responsibility Agreement Form entirely for the person whom you will be taking responsibility for financially, and return it back to the pharmacy via email, mail or fax.

In the beginning of every month, a statement showing an itemized list of medication and co-pays is mailed to the individual listed on the Patient Responsibility Agreement.

For your convenience you have the option to have the monthly statement amount to be automatically charged to a credit card by filling out the bottom half of the Patient Responsibility Agreement/ Credit/Debit Card Authorization Form. This way you can avoid mailing or getting behind on payments. You will be sent out a statement showing charges and payment applied.

Should you have any questions or concerns please contact us at (657) 500-8888 or Email: AR_austindrugs@yahoo.com.

Sincerely,

Billing and Accounting
Austin Drugs Rx
808 W Commonwealth Ave
Fullerton, CA 92832
T: (657) 500-8888
F: (657) 500-8800
E: AR_austindrugs@yahoo.com

Patient Responsibility Agreement / Credit or Debit Card Auto Charge

RESIDENT

Patient Name:_____ Birth date_____ Sex:_____

PATIENT/RESPONSIBLE PARTY

Responsible Party's Name_____ Relationship to Patient_____

Billing Address_____

Home Phone _____

Mobile Phone _____Email:_____

If Applicable, Regional Center Patients – Name of Caseworker_____

Email_____Phone Number_____

I, the undersigned's responsible party, agree to be responsible and to promptly pay in full any indebtedness, obligations and liabilities owing to Austin Drugs Pharmacy by the above listed patient, including, but not limited to, medications, medical supplies and any finance or interest charges. I understand that I will receive a monthly statement from Austin Drugs Pharmacy and that the bill is due and payable upon receipt. I also agree to provide proof of insurance eligibility necessary for Austin Drugs Pharmacy to properly bill for covered pharmacy services. In the event that a medication is not covered or insurance billing is not acceptable, I agree to accept financial responsibility. I understand that although my health insurance provides for prescription benefits because Austin Drugs Pharmacy is located in California it may not be a member of or eligible for membership in an out of state pharmacy provider network.

Signature_____ Date_____

DEBIT CARD OR CREDIT CARD AUTO CHARGE AUTHORIZATION PAYMENT OPTION

I, _____, hereby authorize Austin Drugs Pharmacy to charge the credit or debit card that is describe d below for balances outstanding on my above-listed Austin Drugs Pharmacy account as follows (initial the box or boxes that apply):

□ Austin Drugs Pharmacy may charge my credit or debit card to pay outstanding balances on my account any time I specifically authorize it on the phone.

□ Austin Drugs Pharmacy's accounts receivable department may automatically charge my credit card on or above the __3rd__ day of each month for amounts then outstanding on my account.

□ Other:_____

I unconditionally guarantee payment of all sums owed on my account. I acknowledge that the above payment arrangements are provided as a convenience to me, and are not a requirement for having an account with Austin Drugs Pharmacy or for using my credit or debit card to pay amounts owing on my account. I also acknowledge that I am voluntarily providing the information on this form to Austin Drugs Pharmacy in order to facilitate the above payment arrangements, and that Austin Drugs Pharmacy may keep this document for its records. However, Austin Drugs Pharmacy will use commercially reasonable efforts to keep the information on this document secure, and will destroy this document immediately upon my request.

CREDIT or DEBIT CARD INFORMATION:

Name on Card: _____

Billing Address: _____

Credit/Debit Card #:_____

Expiration Date: _____ CVV2(3 digit security code on back of card):_____

Signature: _____ Date: _____

AUSTIN DRUGS PHARMACY, 808 W Commonwealth Ave Fullerton, CA 92823
Phone: (657) 500-8888 Fax: (657) 500-8800 Email: AR_austindrugs@yahoo.com