Good Day Pharmacy

PHARMACY AGREEMENT

This form authorizes Good Day Pharmacy to provide medications to the individual (resident) named below and provides that financial responsibility incurred from the medications will be paid by the resident, spouse or Legally Responsible Representative (Guarantor).

Community Name: _____ Designate Good Day Pharmacy as one of the following:

(Please fax to Good Day at 970-461-9089 or toll-free 888-810-9089) ☐ **Primary Pharmacy / ☐ Emergency Pharmacy Only**

Resident Name: _____ Phone Number: ____ - ____ - ____

Address: _____ City: _____ St:____ Zip: _____

Social Security #: ____ - ____ - _____ Medicare #: _____ Date of birth: ____/____/____
(Red, White & Blue Card)

Primary Care Physician: _____ Allergies: _____

Responsible Party Name: _____ Phone Number: ____ - ____ - ____

Address: _____ City: _____ St: ___ Zip: _____

Relationship to Insured: _____ Email: _____

Prescription Insurance: *(Please photocopy both sides of the prescription card and attach)*

Insurance Company Name: _____ Phone Number: ____ - ____ - ____

Colorado Medicaid: □ Yes or □ No If 'Yes'; ID #: _____

Statement/Payment Information:

* Each month, an itemized statement including insurance copays and non-covered products will be sent to you along with a self-addressed envelope for your mailing convenience. The 'copays' for medications covered by insurance are noted with a lower case 'c' on the far-right side of the amount listed for each item.

* This statement is payable directly to Good Day Pharmacy upon receipt. If payment is not received by the last day of the month a finance charge of 8% APR of the balance due on all unpaid balances over sixty (60) days will be assessed. Your bill can be paid anytime on GoodDayPharmacy.com.

* If you prefer, we have two convenient ways to pay your bill automatically. See the attached form 'Authorization Agreement for Automatic Payments' for details.

All pharmacies doing business in Colorado are required by Colorado State Law to report all controlled substance prescriptions they dispense to the Prescription Drug Monitoring Program (PDMP) operated by the Colorado Board of Pharmacy. Prescription information in the PDMP may be accessed for limited purposes by persons specified by state law. For more information you may contact the Board of Pharmacy at (303) 894-7800 or www.dora.state.co.us/pharmacy.

By signing this Agreement, I:

- Authorize Good Day Pharmacy to provide medications to the Resident named above effective on the date indicated below.
- Authorize Good Day Pharmacy to substitute generic products, when available, as allowed by my physician and applicable law to contain costs.
- Agree to accept full financial responsibility and guarantee payment of all charges for pharmacy services provided by Good Day Pharmacy that are not covered by third party payors, including Medicare Part D and Medicaid.
- Acknowledge and understand that Good Day Pharmacy cannot accept returns of medications that are not in compliance with the applicable State Board of Pharmacy rules and regulations.

Notice of Privacy Practices (NOPP):

Under applicable law, we are required to maintain the privacy of your Protected Health Information (PHI) and to provide you with notice of your legal duties and privacy practices with respect to PHI. Please visit our website at gooddaypharmacy.com and select PRIVACY POLICY for details. By signing this agreement, you are acknowledging that you been notified of Good Day Pharmacy's Privacy Practices. If you have questions after reading the attached notification, please contact a pharmacy staff member.

_____ _____

Signature of Resident **Date**

_____ _____

Signature of Responsible Party **Date**