Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
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Deposit 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 patient and I understand that by signing this agreement I will become responsible to pay the usual and customary fee for all medications, products, and services provided to The Patient by The Pharmacy at the direction of the facility administration and staff and attending physician(s). 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 and that I am responsible for any co-payments that may arise. I am aware that I am also responsible for payment for all medications, products and services provided by The Pharmacy that are not covered by the PBM. I understand and agree to the following:

- 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.
- The deposited amount is the patient's credit limit. If charges go over the limit, the account will be put on hold until payments are made to bring the balance below the limit. Additional deposits can be added to the account later to increase the credit limit.
- The deposited amount will be determined by the pharmacy and the requested amount will be printed on the Deposit Statement.
- The deposit amount will only be used to pay any closing balances when the patient stops using Ready Meds Pharmacy. I know the deposit amount does not affect the monthly statement balance of the patient in any way. I will pay the full amount due on each statement before the deadline.
- Any remaining credits after closure of the account with The Pharmacy will be sent to the agreed address below as a refund check.

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.

Billing Address: Phone Num:

Depositor Name: Email/Fax:

Depositor Signature: Date:

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