



# PRESCRIPTION PAYMENT PLAN AGREEMENT

## RESIDENT INFORMATION



(Please Print)

Name \_\_\_\_\_ Facility \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S.N. \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance Plan \_\_\_\_\_ (Please attach a copy of insurance card, both front and back)

Nearest Relative \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_

## PAYMENT INFORMATION

Responsible Party Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

**I hereby authorize payment for charges to the BHS Pharmacy account using the following payment method:**  
(Check One)

\_\_\_\_\_ **Credit Card/Debit Card**

CC/DC # \_\_\_\_\_ Exp Date \_\_\_\_\_

Credit card and debit cards will be preauthorized in the amount of the expected monthly account charges.

\_\_\_\_\_ **Automatic Bank Withdrawal**

Save time, stamps, and envelopes by using Automatic Withdrawal. (To use this method of payment attach a blank check with the word VOID written across the face of the check).

\_\_\_\_\_ **Prepaid Deposit** Amount of Deposit \$ \_\_\_\_\_

Prepaid deposits must be greater than the expected monthly account charges. All account charges must be paid in full within 30 days of the statement date to avoid late charges.

**I also agree to the following BHS Pharmacy account terms and conditions:**

A statement will be issued by the seventh day of each calendar month to the Responsible Party via email, fax, or USPS. The amount of the current monthly account balance is immediately due on the statement date regardless of any discrepancies or disputes and will be paid by one of the above payment methods within 10 (ten) days after the statement date. If for any reason, including short payments, the account is not paid in full within 30 days of the statement date you agree to be charged a \$25 late fee for each month the balance is outstanding. The Responsible Party agrees to notify BHS Pharmacy in writing at the address listed below of any discrepancies or disputes within 15 days of the original statement date. If legal action is needed to recover any outstanding account balances, including late fees, the signed Responsible Party agrees to pay attorney fees, all related court costs and any collection agency fees in addition to the outstanding account balance. BHS is not responsible for insurance billing prior to notification of insurance coverage. BHS reserves the right to change the above conditions without notice.

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RESPONSIBLE PARTY'S RELATIONSHIP TO RESIDENT \_\_\_\_\_