WELCOME!

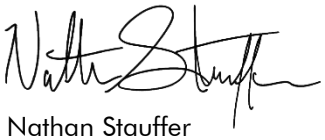
It is my privilege to announce that your community director has selected Guardian Pharmacy to be their preferred pharmacy provider. Our pharmacy is dedicated to delivering the highest possible level of care to residents of assisted living, skilled nursing, and residential mental health facilities throughout Michigan. Through our partnership with your community, we will deliver the best possible service and ensure you get the medications you need, when you need them, safely – and at the right price

WHY USE GUARDIAN?

- **Cost Management** - Guardian Pharmacy coordinates directly with your physicians and third-party insurance providers to maximize your insurance benefits
- **Billing Support** - Unlike a retail pharmacy, Guardian bills medications monthly, and our local billing staff is always ready to answer billing-related questions
- **Enhanced Safety** - Our pharmacy is closed to the public and features enhanced sanitation protocols, touchless delivery, and smart packaging to maximize your safety
- **Medicare Guidance** - Guardian helps you understand your Medicare Part D coverage and can offer one-on-one consultations during open enrollment
- **Clinical Support** - Our pharmacists conduct ongoing medication reviews to ensure your medications are compatible and appropriate for you
- **Compliance Packaging** - Easy-to-use packaging options, required by your community, organize your medications, and minimize risk of error
- **Timely Delivery & Emergency Support** - Scheduled and emergency deliveries are available 24/7/365, eliminating trips to the local retail pharmacy or delays in receiving medications mail
- **Integrated Technology** - Guardian's seamless integration with your community's electronic medication administration record (eMAR) system eliminates transcription errors and improves medication management

Guardian designs services to make sure you never have to worry about your medication needs. That's why your community has chosen Guardian as their preferred pharmacy provider. We are very excited for the opportunity to serve you. If you have any questions, please contact us at (616) 965-7480.

Sincerely,



Nathan Stauffer
President, Guardian Pharmacy of Michigan

PHARMACY SERVICES AGREEMENT

Guardian Pharmacy of Michigan
Ph: 616.965.7480 | Fx: 616.974.8205

This is an agreement for pharmacy services with Guardian Pharmacy of Michigan and

_____ and _____

[RESIDENT] [RESPONSIBLE PARTY]

In exchange for Guardian Pharmacy of Michigan's agreement to provide me with medications, I agree to the following terms and conditions:

1. **AUTHORIZATION FOR MEDICAL TREATMENT**. I authorize Guardian Pharmacy of Michigan, at the direction of my physician, to provide medications to me. I certify that no guarantee or promise, express or implied, has been made to me in conjunction with the medications that have been prescribed for me.
2. **MEDICAL RESPONSIBILITY**. I understand that I am under the supervision and control of my attending physician and that my physician has prescribed the medication therapy that is being supplied by Guardian Pharmacy of Michigan. Guardian Pharmacy of Michigan does not provide diagnostics, prescriptions, products, or other functions unless otherwise authorized in writing by a physician. Accordingly, I understand that it is solely the responsibility of my physician to advise me on prescription medications and therapies, including why they are part of my treatment and how they may impact my condition.
3. **FACILITY INVOLVEMENT**. I understand and agree that in order to provide me with the best treatment possible, Guardian Pharmacy of Michigan share health information related to my medical condition, treatment, medication regimen, etc. with my long-term care facility or any of my treating physician. In recognition of this need, I authorize Guardian Pharmacy of Michigan to share any necessary patient health information related to me with my facility or physician. I also authorize facility personnel to purchase medications, or other health care products that I may need, on my behalf.
4. **FINANCIAL RESPONSIBILITY**. In consideration of Guardian Pharmacy of Michigan supplying me with physician-requested products or services, I agree and accept responsibility for the payment of all sums that may become due for medications provided to me by Guardian Pharmacy of Michigan. If, for any reason, Guardian Pharmacy of Michigan does not receive payment from my insurer or a third-party payor that is obligated to pay for my medications, I do hereby agree to pay Guardian Pharmacy of Michigan directly for the unpaid balance within thirty (30) days of each monthly statement date. A credit card may be required to secure your account.
5. **PAYMENT OF BENEFITS.** I authorize Guardian Pharmacy of Michigan to submit a claim(s) to my insurance carrier or a third-party payor that is obligated to pay for all covered prescriptions or durable medical equipment. I further direct my insurance carrier or third-party payor to issue any payments directly to Guardian Pharmacy of Michigan.
6. **ASSIGNMENT OF BENEFITS.** I authorize Guardian Pharmacy of Michigan to request and collect on my behalf all public and private benefits due for the products and services supplied by Guardian Pharmacy of Michigan. In the event any payments are made directly to me, I agree to promptly endorse and forward such payment to Guardian Pharmacy of Michigan.
7. **UNPAID INVOICES.** Guardian Pharmacy of Michigan encourages residents to keep their accounts in good standing. However, if my account becomes past due, I agree that any amounts outstanding for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of one and a half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs or expenses incurred by Guardian Pharmacy of Michigan related to collection efforts, including reasonable attorneys' fees and court costs.
8. **WITHHOLD SERVICES.** Guardian Pharmacy of Michigan reserves the right to discontinue services to my account if I have not paid the account in full within 60 days. Payments that remain delinquent may be turned over to collections.
9. **RELEASE OF INFORMATION.** I authorize any insurer or third-party payor who provides me with coverage to disclose to Guardian Pharmacy of Michigan any information regarding such coverage, including but not limited to the scope and extent of coverage available, as well as information related to any payments made on my behalf for services rendered by Guardian Pharmacy of Michigan. I also authorize all medical personnel to disclose information to Guardian Pharmacy of Michigan relating to my medical history as it related to pharmacy services or therapy.
10. **HIPAA AUTHORIZATION.** I give permission to Guardian Pharmacy of Michigan to use or disclose certain aspects of my health information to: the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

I have read and understand the above terms and conditions and agree to be bound by each of them:

Signature [Resident or Responsible Party]**:** _____ **Date:** _____

RESIDENT ENROLLMENT FORM

RESIDENT DEMOGRAPHIC INFORMATION (*indicates required field)

Name*: _____
[First] [Middle] [Last]

DOB*: ____/____/____ SSN*: _____ ☐ MALE* ☐ FEMALE*

Allergies*: _____

Primary Care Physician: _____ Room Admitting To: _____

Previous Pharmacy: _____ Pharmacy Phone: _____

RESPONSIBLE PARTY INFORMATION (*indicates required field) ☐ Resident is own responsible party

Name*: _____
[First] [Middle] [Last]

Relationship to Patient*: _____ Email: _____

Mailing Address*: _____
[Street] [City] [State] [Zip]

Primary Phone*: _____ Secondary Phone: _____

Monthly statements will be mailed to the responsible party ***an alternate party must be listed if resident is primary****
Alternate Responsible Party Name*: _____

Phone*: _____ Address*: _____

PRESCRIPTION DRUG COVERAGE (*indicates required field)

If a photocopy of the insurance cards/Medicare cards [front and back] are included, you may skip this section

Medicare ID Number*: _____ Prescription Drug Plan*: _____

Some commercial insurance plans do not cover Long Term Care (LTC) Services. If your plan does not cover these services, a fee for LTC services received may be reflected on your statement

PAYMENT INFORMATION (*indicates required field **a valid credit card is required to be kept on file to secure this account)

Name on Card*: _____ Primary Phone*: _____

Card Number*:_____Expiration Date (MM/YY)*: ____/_____

Security Code*: _____ *visa/mc/discover: 3 digits on back of card *amex: 4 digits on front of card

Billing Address*: _____
[Street] [City] [State] [Zip]

Please Select an Option: ☐ Please enroll me in monthly autopay ☐ I will mail payment in by check or over the phone

**If payment is not received from resident within 60 days, Guardian will attempt to contact the responsible party. After which, if payment still has not been received, payment will be drafted from card on file. Credit card will only be used after Guardian notifies responsible party of non-payment of an outstanding balance. Guardian reserves the right to withhold services if payment is 90 days or more past due and no good faith effort has been made to bring the balance current. Payment that remains delinquent may be turned over to collections and reported to credit reporting agencies.*

Resident/Responsible Party Signature:_____ Date: _____

For Additional information on Guardian Pharmacy Policy and Procedures: https://guardianpharmacymichigan.com