

PHARMAHEALTH PHARMACY *Life's Total Care* **Responsible Party Statement**

We are pleased to inform you that PharmaHealth Pharmacy will provide the pharmaceutical needs for _____. PharmaHealth Pharmacy strives to provide the highest quality of medication services at the most reasonable prices. Whenever possible, we use generic medications and try to provide the most economical quantities consistent with the regulations of the Commonwealth of Massachusetts.

In order to establish a charge account or debit card, we will need the information noted below. We will attempt to coordinate with any special billing requirements, so please attach **copies of insurance cards or forms that you may need completed.**

PharmaHealth Pharmacy is pleased to charge your Visa Card, MasterCard or Discover Card for your portion of the cost of prescriptions. Please list your account numbers below:

Card Type (Visa, Master, etc.) **Complete** Account Number Expiration Date Vin Number

Signature of Party Holding the Card to be Charged (**required**)

For those residents who prefer to be billed monthly (vs. charging a credit card or debit card), statements are issued at the close of each month and are due in full upon your receipt. If you dispute a billing, you have fifteen (15) days from your receipt of the statement in which to inform us in writing of the dispute. Delinquent and past due accounts are subject to finance charges and discontinuance of pharmaceutical services.

Thank you for the opportunity to serve your pharmaceutical needs.

Legal Name of Patient

Room Number (if applicable)

Birth Date

Social Security Number

Party Responsible for Payment (please print)

Daytime Phone

Responsible Party's Mailing Address

Signature of Responsible Party

Date

FOR PRESCRIPTION CHARGES ONLY