1. DOWNLOAD THIS FILLABLE FORM BY SAVING IT TO THE DESKTOP

2. FILL IN ALL APPLICABLE FIELDS BY TYPING IN DESIGNATED BOX

3. YOU MUST SAVE THE FILLED IN FORM TO YOUR DESKTOP BEFORE RETURNING!!!!

NOT SAVING THE FORM WILL RESULT IN SENDING US A BLANK.
SIMPLY SAVE THE FORM OVER THE EXISTING DOWNLOAD AND EMAIL
OR PRINT AND FAX THAT SAVED FILE TO US!

THE ATTACHED FORM MUST BE RETURNED WITHIN 7 DAYS TO OUR PHARMACY

Dear Patient and/or Responsible Party,

Advanced Specialty Rx would like to welcome you and your loved one to our pharmacy!
Our friendly staff is here to ensure that your transition into our pharmacy goes as smoothly as possible, and we look forward to establishing a close relationship with you and yours!

Our mission is to provide first class pharmacy services to our partnered facilities and residents; with dedication, compassion, integrity, respect, and honesty. Our goal is to provide the services in a way that we would proudly serve our own families.

Enclosed you will find a copy of our *Resident Responsible Party Agreement.* This form **MUST** be completed in order to serve you and your loved one efficiently. Please complete the Agreement and return within **7 days**. We must have form on file to continue filling your loved ones prescriptions. Please be aware that not all medications are covered under some insurance. In the event that the prescription is not covered, *Advanced Specialty Rx* can offer you the best out-of-pocket price! As a valued customer of *Advanced Specialty Rx*, we are able to offer payment options to best fit your needs. We accept all major credit cards and automatic payment set up through your financial institution.

- Credit Card payments will take place on 10th of each month with the current balance due.
- ACH Bank Deduction will take place on 20th each month with the current balance due.

In order to comply with the Privacy Practices Act, please provide copies of any court documents, stating who the responsible party is for the patient.

Be advised that, if your account becomes delinquent over **60 days** with no form of communication from payee, *Advanced Specialty Rx* will be obligated to discontinue service until payment is received. We welcome all questions and concerns that you may have about our service or bills that are unclear to you. Please be aware that the staff at the facility **cannot** handle pharmacy billing questions. Please direct your calls to the listed contacts below.

Please contact us directly:

- **Accounts Receivable Questions: Nancy (810) 232-8001 or Michele (810) 671-0534**
- **Insurance Coverage or Medication Billing Questions: (810) 671-0422**

- Please fill out and return all signed documents enclosed to:

Fax: 863-329-2779
Email: michele@asrxmi.com
Mail: Advanced Specialty Rx Pharmacy
Attn: Michele Bemis
4488 W Bristol Rd, Ste 350
Flint, MI 48507

Yours Truly,

Nancy Cadroy

Nancy Cadroy: Director of Administration

REVISED FORM 2025

Advanced Specialty RX Pharmacy
Resident/Responsible Party Agreement

Please complete entire form and return within 7 days

In order to comply with the Privacy Practices Act, please provide copies of any court documents stating who the Responsible Party is for this patient.

Thank you

BILLING INFORMATION

Name of Resident: _____ Male/Female DOB: _____

Community Name: _____

Name of Responsible Party / POA: _____ Driver's License #: _____

Address of Responsible Party / POA: _____

City: _____ State: _____ Zip Code: _____

Physical Address If Mailing to a PO Box: _____

Phone Number of Responsible Party / POA: _____ Relationship to Resident: _____

PAYMENT INFORMATION

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree that community personnel are authorized to order purchases and charge on behalf of the above named resident.
- I agree to pay all charges incurred by the above named resident that are not paid for by third party payers, including Medicaid, and/or any over-the-counter medication.
- I will pay the entire amount due within terms of the statement in accordance with each statement.
- I agree that in order for the individual account to remain active, payment for billed charges must be made promptly pursuant to these terms.
- I agree to pay all costs of collection, including court costs and attorney's fees, for all delinquent balances.
- Any inquires about the Monthly Statement must be addressed as soon as statement is received.
- I understand that the medications furnished to the above named individual are not packaged in child-proof containers.

Options for Payment ***please SIGN and complete information for chosen option (1, 2 OR 3)***

#1) __ I will pay the balance monthly by ACH Bank Deduction. **the monthly statement will be mailed to you by the 10th of each month for review. On the 20th of that month, the amount due will be withdrawn via ACH (through Chase Bank) I, _____ grant Advanced Specialty Rx authorization to deduct monthly payments from my checking/savings account once each month for the balance due.

Checking or Savings Account #: _____ Bank Routing#: _____

Name on Account: _____

Signature: _X_____ Date: _____

#2) __ I will pay the balance monthly by CREDIT CARD. I understand that my card will be charged at the end of each Billing cycle (approximately the 10th of each month) & the receipt will be mailed to you with the statement.

Please charge my: _____VISA _____MasterCard _____Discover _____American Express

Card Number: _____

Expiration Date: _____ 3 digit Security code: _____ Zip code: _____

Name on Card: _____

Signature: _X_____ Date: _____

#3) __ I will pay the balance monthly by Check/Money Order within 10 days of receipt of Statement **

Name: _____

Signature: _X_____ Date: _____

I agree to the above terms and conditions. I also agree that I received a Customer Agreement, Notice of Privacy Practices, and Medicare Supplier Standards *(Attached pages).*

Signature: _X_____ Date: _____

Please contact Nancy at 810-232-2700 Ext: 121 if above payment options cannot be arranged

**Any return for Non-sufficient Funds by banking institution will incur a $25.00 fee.

Please Return to: MAIL: Advanced Specialty Rx, 4488 W. Bristol Rd Ste 350 Flint, MI 48507 Attn: Michele.

FAX: 863-329-2779 EMAIL: Michele@asrxmi.com

Customer Agreement

Facility Name: _____

Customer Name: _____

Each month an itemized bill for non-covered services will be sent to you, this bill is payable Directly to Advanced Specialty Rx Pharmacy (ASRX). ASRX accepts payment via Credit Card and Ach Bank Deductions. Please see FORM 4214 labeled Resident/Responsible Party Agreement, to confirm on how your payment will be submitted.

By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the following terms:

1. **Authorizations**: Advanced Specialty Rx Pharmacy and its subsidiaries ("ASRX") are authorized to provide the patient all products and services prescribed or ordered by the Patient's Physician or by the facility. The Patient requests the products provided by ASRX be dispensed in containers that are not child resistant. The Patient requests that the Facility and/or ASRX dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to the facility and pharmacy policy as allowed by professional standards and regulations: excluding controlled substances.
2. **Assignment of Benefits**: The Patient or Legal Representative hereby requests and authorized any third-party payer to make payment directly to ASRX for products and Services provided to the patient.
3. **Payment**: The Patient and Financially Responsible Party are responsible for pay all charges for products and services provided to the Patient by ASRX. As a courtesy, ASRX will submit claims to any insurance companies or other third-parties listed above or of which ASRX is subsequently notified in writing; however, the Patient and Financially Responsible Party are ultimately responsible for paying any charges not covered by insurance or another third party payer. The patient or their Legal Representative and/or Financially Responsible Party hereby authorize ASRX to charge any credit card or bank account number identified above for any amounts owed.
4. **Assurance of Payment**; **Termination of Services:** The Patient or Legal Representative and Financially Responsible Party acknowledge that if the Patient and Financially Responsible Party are delinquent on payment of any amount owed to ASRX, ASRX may, in its sole discretion, do either or both of the following: (a) condition its continued provision of products and services to the Patient upon ASRX's receipt of assurance of payment acceptable to ASRX, which may include, without limitation, a requirement that ASRX receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Patient. Such suspension or termination will in no way affect the Patient's or Financially Responsible Party's obligations to pay all amounts owed under this agreement, including costs or collection.
5. **Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations**: The Patient or Legal Representative herby authorizes ASRX, its employees, agents, and sub-contractors to disclose to the Medicare or Medicaid program or to any other third party payer any medical or other information needed for payment for all products and services provided by ASRX to the Patient until payment has been made in full. The Patient or Legal Representative further authorizes ASRX, its employees, agents, and Sub-contractors to use the disclose the Patient's medical and other information for the provision of products and services, for the business operation of ASRX and the review of ASRX's services, including review by accrediting bodies of governmental agencies.

The undersigned certifies that he/she has read the above information and received a copy as well as a copy of Customer Rights and Responsibilities and Medicare Supplier Standards. The undersigned also certifies that he/she is the customer, or is authorized by the customer to execute the above and accept its terms, and is personally and fully responsible for payment. The undersigned guarantor (in addition to the above payee) has executed this document to induce ASRX to enter into this agreement and acknowledges ASRX would not enter into this agreement without guarantor's signature.

Guarantor/Guardian/Payee Signature: _____

Printed Name: _____ Date: _____

Advanced Specialty Rx
4488 W Bristol Rd, Ste 350, Flint, MI 48507 Phone: (810) 232-2700 Fax: (863) 329-2779

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

SECTION A: Uses and Disclosures of Protected Health Information

Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information"). We are also required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information (referred to as "PHI") and to abide by the terms of this notice, as it may be updated from time to time. We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes. For treatment purposes, such uses and disclosures will take place in providing, coordinating, or managing healthcare and its related services by one or more of your providers, such as when your pharmacist consults with your physician or a specialist regarding your medications, treatment or condition. For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing pharmaceutical care services, such as when your case is reviewed to ensure appropriate care was rendered. For reimbursement purposes, your PHI may be disclosed to one or several intermediaries employed by your plan sponsor including but not limited to insurers, pharmacy benefits managers, claims administrators and computer switching companies.

For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement, provider review and training, underwriting activities, reviews and compliance activities; planning, development, management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care you were provided. In addition, we may contact you to provide refill reminders, health screenings, wellness events, inoculations, vaccinations or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, we may disclose your health information to your plan sponsor. In addition, we may contact you for the purpose of fund raising activities, unless you object.

We may use and disclose your PHI, without your authorization, when the pharmacy needs to contact a physician or physician's staff and is permitted or required to do so without individual written consent or authorization. We may use and disclose your PHI if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them. From time to time, we may employ the services of business associates who may assist us in one or more tasks and who may use, change or create PHI. Business associates are required to comply with all the privacy regulations on your behalf. We may disclose PHI about you without your authorization to comply with workers compensation laws, as required by law enforcement, legal proceedings, public health requirements, health oversight activities and as required by law.
Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization at any time by notifying us as described in Section B, except to the extent the Pharmacy has already taken action in reliance on a previously signed -authorization form.

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request. You have the right to request the following with respect to your PHI: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of the disclosures of this information by us; (We are not required to account to you for disclosures made for treatment, payment, operations, disclosures to you, disclosures to your care givers, for notifications or as otherwise excluded by law); and (iv) receipt of a paper copy of this notice upon request. The Pharmacy may require patients to make requests for access to their PHI in writing. In addition, you may request, and we must accommodate the request, if reasonable, to receive communications of PHI by alternative means or at alternative locations. To make this request please contact us as described in Section B.

We may use your name to reference your prescriptions and pharmaceutical care services. You may be required to sign a signature log form or to acknowledge receipt of service, to acknowledge receipt of this notice and the disclosure of PHI as outlined herein. We may disclose this information to other persons who ask for you or your prescriptions by name. You may restrict or prohibit these uses and disclosures by notifying a pharmacy representative orally or in writing of your restriction or prohibition. We are not required to honor those requests. If you request our services, we are able to provide treatment services to you, even if you object to signing the
acknowledgment of the receipt of this notice or if we decide not to honor a request regarding the information in this document while noting your requests and refusals in our records. In the event of an emergency or your incapacity, we will do in our reasonable judgment what is consistent with your known preference, and what we determine to be in your best interest. We will inform you of any such uses or disclosures under such circumstances and give you an opportunity to object as soon as practicable.

We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care. In addition, unless you object, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our
judgment and experience regarding your best interest in allowing people to pick-up filled prescriptions, or similar forms of PHI.

We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI we maintain. You may receive a copy of this notice by contacting us as outlined in Section B or upon the receipt of pharmacy care services.

If you believe that your privacy rights have been violated, you may file a complaint with us at the location described in Section B or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200Independence Ave SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Section B: Contacting Us

You may contact us for further information at:
Advanced Specialty Rx
4488 W Bristol Rd, Ste 350
Flint, MI 48507
(810) 232-2700

_____ _____

Residents Name Facility Name

_____ _____

Sign and date that you have read Advanced Specialty Rx's Privacy Practices Date

Medicare Supplier Standards
Customer Rights
Form 42915

MEDICARE SUPPLIER STANDARDS

In response to orders which it receives, Advanced Specialty Rx Pharmacy:

- Fills orders from our own inventory or inventory of other companies with which it has contracted to fill such orders and who are not excluded from the Medicare program;
- Is responsible to oversee delivery of items that the supplier ordered for the beneficiary; also responsible to assure delivery of large items to the beneficiary;
- Honors all warranties, expressed and implied, under applicable State Law;
- Will answer any questions or complaints a beneficiary has about an item that is sold or rented to the beneficiary and refers beneficiaries with Medicare questions to the appropriate carrier;
- Maintains and repairs directly, or through a service contract with another company, items it rents to beneficiaries; accepts returns of substandard (less than full quality for particular item) or unsuitable item (inappropriate for the beneficiary at the time it was fitted and or sold) from the beneficiaries;
- Discloses consumer information to each Medicare customer, which consists of a copy of these supplier standards to which it must conform;
- Complies with the disclosure provisions in Title XI of the Social Security Act, section ii24A;
- Has proof of appropriate liability insurance;
- Provides HCFA “upon request” with documentation which shows that HTP adheres to the standards, as well as copies of contracts with other providers or payers;
- Informs beneficiaries of their options to rent or purchase inexpensive, routinely purchased equipment or crapped rental equipment;
- Maintains a physical facility which contains space for storing business records;
- Contacts beneficiaries about a covered item only under certain conditions, including if the beneficiary has given written permission;
- Only uses licensed Pharmacies to dispense to bill Medicare for drugs used as a Medicare covered supply;
- Does not charge for the repair or replacement of Medicare covered items or for services covered under warranty;
- Does not contract with any entity excluded from any Federal or State health care program, or government procurement or non-procurement program;
- Does not convey or reassign supplier number;
- Note: If you do not know which Regional Carrier to call please ask the supplier where your claims are billed. Medicare Beneficiary “800” Hot Line Numbers:

  Region A (800) 842-2052 Region C (800) 213-5452
  Region B (800) 622-4792 Region D (800) 899-7095

CUSTOMERS RIGHTS

A Customer receiving health care products has the right:

1. To receive appropriate and professional quality services without discrimination based on race, creed, color, religion, sex, national origin, handicap, sexual preference, or age.
2. To receive information necessary to provide an informed consent for care that includes an explanation of all services and/or treatments Advanced Specialty Rx Pharmacy is to render, and when and how such services/treatments will be provided.
3. To timely service and response to reasonable inquires.
4. To privacy and appropriate confidentiality of records, including the right to consent to the release of records to any individual not employed by ASRX (except physicians or other medical personnel consulting on his or her medical condition or in the care of his or her transfer to a health care center, or as required by law or third party payment contract, or as required by a federal, state or accrediting body or agency).
5. To be informed regarding charges and payments for services, including availability of third party coverage and reimbursement
6. To examine records kept by ASRX relating to him/her, unless medically contraindicated as documented and signed by his/her physician