RESPONSIBLE PARTY GUARANTEE

PLEASE COMPLETE UPON ADMISSION & FAX TO 866-262-1021

I understand that all the pharmaceutical charges incurred by _____, a resident of_____, will be billed to me and paid within 30 days of the invoice date. Payments should be made to directly to:

Dept #7554
Guardian Pharmacy of Iowa
Cedar Rapids LTC PO Box 415000
Nashville, TN 37241-7554

Payments can be automatically charged to a credit card or ACH withdrawal from bank account (another form needs to be filled out for those options.)

In the event there is a change in source of payment, I will notify Right Dose Pharmacy immediately for timely handling of my new payment option (Title XIX, Insurance Plans, etc). Copies of all drug and coverage cards (front and back) must be provided to Right Dose Pharmacy so new plan coverage may be verified.

Any non-covered or co-pay charges that have been denied by any type of insurance plan will be my responsibility to pay.

_____ _____

Responsible Party Signature Date

_____

Responsible Party Printed Name

_____

Street Address

_____

City, State, Zip

_____

Phone (including cell phone #'s)