

**Moye's Long Term Care Pharmacy**  
**1922 Hudson Bridge Road**  
**Stockbridge, GA 30281**  
**(770)507-1559**  
**(770) 507-1011 fax**

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**Resident's Information**

Resident's Name: \_\_\_\_\_ Move-in Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Assisted Living Home: \_\_\_\_\_ Room# \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

List of Drug Allergies (ie. Penicillin, Aspirin, etc...)

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List of Other Known Allergies (ie. Iodine, Seafood, etc...)

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**Primary Physician's Information**

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Office Phone Number: (\_\_\_\_) \_\_\_\_\_

**Pharmacy Insurance Information** (Please include front & back copy of all insurance cards)

Name of Insurance: \_\_\_\_\_

Card ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Ins. Phone #: \_\_\_\_\_

Medicare # \_\_\_\_\_

Social Security Number \_\_\_\_\_

Do you have mail order pharmacy coverage?  Yes  No

If yes, do you plan to use the mail order pharmacy and have Moye's repackaging?  Yes  No

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**(For Office Use Only)**

Medication Management

Self-medicates

\*Medications need to start on \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_:\_\_\_\_ am/pm

Type of Diet: \_\_\_\_\_



**Financial Information**

**Please enclose a copy of any power of attorney documents and a copy of Driver's License  
Power of Attorney/ Guarantor Information:**

Name: \_\_\_\_\_ Relationship to Resident: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone#: \_\_\_\_\_  
 \_\_\_\_\_ Work Phone#: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Driver's License No \_\_\_\_\_ State \_\_\_\_\_  
 Name of Nearest Relative (Not Living with You) \_\_\_\_\_  
 Relationship \_\_\_\_\_ Phone #: \_\_\_\_\_

**Pharmacy Financial Agreement**

We both understand that Moye's Long Term Care Pharmacy will provide medications and other supplies requested by the physician &/or assisted living facility personnel. The responsible party will be accountable for payment of these items ordered. **Once medications have been delivered to the facility, medications may not be returned for a credit. Also, it is the facility and the guarantor responsibility to notify Moye's Pharmacy of any change in the resident's status at the facility, such as in the hospital, moved out, or deceased. Moye's Pharmacy must be notified of any status change within 24 hours. If Moye's has not been notified of a status change & medications are delivered, the resident may be subject to a \$50.00 restocking fee.**

Moye's Pharmacy's monthly billing cycle is every thirty (30) days. I understand payment is due within fifteen (15) days of my receipt of the statement. I also understand that if I fail to pay for any prescription medication when due, I will be charged interest on all monies due at the rate of 18% per month until paid, but in no event more than the maximum rate permitted by law. Whenever any payment is not made by me when due hereunder, I agree to pay to Moye's Long Term Care Pharmacy an administrative charge to offset Moye's Long Term Care Pharmacy's collection expenses in an amount calculated at the rate of ten cents per one dollar for each such delayed payment; or fifteen dollars (\$15.00), whichever is higher. Such an amount shall be payable in addition to all amounts payable by me as a result of the collection efforts of Moye's Long Term Care Pharmacy to collect any amounts overdue.

Moye's Pharmacy charges a one time a month \$25.00 service fee. Any medications that are deemed as an emergency order & must be delivered after a scheduled delivery may be subject to a \$10.00 delivery fee.

We hereby authorize Moye's Pharmacy to obtain any credit information concerning the date herein, and to retain this information together with this statement. I hereby certify that the above information is correct and complete. We understand all the terms and conditions of this agreement.

We represent that if the signature of a responsible party below is that of a corporation, the party signing for the corporate entity has the authority to do so.

We as the resident and responsible party signed below, consent to the personal jurisdiction of the courts of the State of Georgia and the venue of Henry County, Georgia with respect to any action arising out of any agreement, guarantee, settlement agreement, promissory note, or other accommodation or agreement with Moye's Long Term Care Pharmacy. This means that any legal action filed against me and/or any guarantor or responsible party may be filed in the Superior Court of Henry County and that we may be required to defend and litigate any such action in Henry County, Georgia. We also agree that service of process by certified mail, return receipt requested, shall be deemed the equivalent of obtaining service of process and personal service in such action. Further, to the extent permitted by law, we waive trial by jury in any action and further waive any and all rights and remedies we may have under the Uniform Commercial Code as codified in the State of Georgia

This agreement constitutes the entire agreement between the parties, superseding all previous proposals, oral or written. No representation or statement not contained on the original of this agreement shall be binding as a warranty or otherwise, nor shall this agreement be modified or amended except in writing, signed by the parties hereto. We also expressly disclaim having relied upon any representation or statement concerning the medications received from Moye's Long Term Care Pharmacy.

\_\_\_\_\_  
Resident's Signature/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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### **Guaranty**

I guarantee that the resident will pay all payments and other sums due under this financial agreement when due, and that the resident will perform all other obligations as required by this agreement. I also agree that Moye's Long Term Care Pharmacy may make other arrangements with the resident, and I will still be responsible for the resident's payments and obligations under the agreement as amended. If the resident defaults under this agreement, I agree to immediately pay all amounts due without notice from Moye's Long Term Care Pharmacy of the resident's default, plus any attorneys fee and other costs. I agree that this guaranty continues until all payments under this financial agreement have been paid in full, and that the above paragraph regarding jurisdiction and governing law shall apply to me.

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date