FINANCIAL RESPONSIBILITY AGREEMENT
BY AND BETWEEN
REALO EXTENDED CARE PHARMACY
AND

Resident: Name:_____

Facility:_____ Room:_____ Date of Admission:_____

Prescription Insurance Carrier:_____

(Note: Attach a photocopy, front and back, of the insurance card)

BY

Legal Representative: Name:_____

Address:_____

City, State, Zip:_____

Phone: (Home)_____ (Work)_____

OR

Responsible Party: Name:_____

Address:_____

City, State, Zip:_____

Phone: (Home)_____ (Work)_____

Realo Extended Care Pharmacy ("Pharmacy"), agrees to provide medications ordered by the resident's physician in accordance with the following terms:

1. The resident, resident's legal representative, and where appropriate, the responsible party shall pay the pharmacy charges for medications ordered by the resident's physician(s) out of resident's funds.

2. Prescription insurance information will be forwarded to the Pharmacy at the time of admission or stat of coverage. Pharmacy will attempt to contract with insurance companies that reimburse at a fair and customary rate. Pharmacy maintains the right not to contract with certain insurance companies which reimburse below the fair and customary rate. Payment is expected for purchases not payable by the Third Party Insurance source.

3. Payment in full is expected within 30 days of receipt of the monthly statement. For the account to remain active, the account must remain current, and it is understood that no additional purchases will be allowed on this account when it becomes 30 days past due.

4. Facility personnel may authorize purchases on this account on behalf of the named resident.

The undersigned certify that they have read the above and hereby accept these terms and conditions:

_____	_____	_____
Signature of Resident	Date	Witness
_____	_____	_____
Signature of Legal Representative	Date	Witness
_____	_____	_____
Signature of Responsible Party	Date	Witness

Resident Name:_____ Medical Record#_____