NEW ADMISSION

SIGNED ACKNOWLEDGMENT
FAX 509.455.4479
PHONE 509.455.9345

Resident Name: ____ **DOB:** _________ /_________ /_________

<u>Prescription Packaging, Privacy Practice & Responsible Party Acknowledgment</u>

WAC 246-869-230 states that all legend drugs intended for oral use shall be dispensed in child resistant containers (CRC) as required by Federal law or regulation, unless authorization to use a non-CRC is obtained from the prescriber, patient, or patient's representative.

I request that all prescriptions be dispensed in non-child resistant containers. Sixth Avenue Pharmacy uses packaging which allows ease of use for caregivers and patients, with the intent being safe and efficient delivery of medication(s). I hereby acknowledge that I have received a copy of Sixth Avenue Pharmacy Notice of Privacy Practices.

I understand that l am financially responsible to Sixth Avenue Pharmacy for all charges incurred by the above named resident including collection fees, attorney fees, and court costs. If the resident has state Medicaid, all non-covered medications and supplies will be billed to the resident, unless prohibited by regulations. I understand that I am responsible for payment of any medication or other charges to the above named resident not covered by third party insurance while he/she resides at this facility.

Statement balances will be paid in full immediately upon receipt unless other arrangements are made. If the amount is not paid in full within thirty (30) days after due date, a late charge may be incurred, computed at 1 percent (1%) of the unpaid balance for each month, or part thereof, that is not paid in full. If the balance is not paid in full within sixty (60) days or a payment plan has not been arranged and agreed upon, provision of medications and supplies may be suspended.

Signature ____ **Date** __________________________

Printed Name: ____ **Relationship:** ___________________

PLEASE INCLUDE A DETAILED FACE SHEET ALONG WITH THIS SIGNED FORM

Billing Contact:____ **Phone:**____________________________

Billing Address:____

City:____**State:**__________ **Zip:**____________________