

INNOVATIVE PHARMACEUTICAL PACKAGING CORP
703 GINESI DRIVE, MORGANVILLE, NJ 07751
Phone (732) 617-8686 Fax (732) 617-8321

RESPONSIBLE PARTY AGREEMENT

Personal Information:

Community Name: _____
Name of Resident: _____ Date of Birth _____
Check One: Male Female Social Security Number: _____
Responsible Party Name: _____
Responsible Party Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Employment Phone: _____
Relationship to Resident: _____

Financial Information:

Private Pay Private Insurance Medicaid Pending Medicaid - Applied _____
 Medicare D

You must provide a photocopy of the front & back of your prescription insurance card.

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree that community personnel are authorized to order, purchase and charge on behalf of the above resident.
- I agree to provide the pharmacy with a photocopy of the front and back of the insurance cards used for prescription coverage.
- I agree to notify the pharmacy of any future changes in prescription coverage.
- I agree that any medication that has been discontinued or expired will be destroyed by the Facility and /or Pharmacy.
- I agree to pay all charges incurred by myself or the above named resident not paid for by third party payees, including Medicaid.
- I agree in order for the account to remain active, the account must remain current.
- I agree to pay all costs of collection including court costs and attorney's fees, if necessary, in order to collect any and all delinquent balances.
- I understand that the medications furnished to the above named resident are not packaged in child-proof containers.

(Responsible Party/Guarantor) (Date)
As a recurring transaction, _____ Or **Mastercard** _____
you may charge my **Visa** _____
Account No. _____ Expiration Date _____
3-digit code on back of card (CVA#) _____

(Signature) (Date)