

Payment Information

For your convenience, Reeves-Sain will bill your insurance for all eligible medications in your Reeves-Sain shipment. The remaining balance will be your responsibility to be paid within 30 days from the statement date on the monthly statement that will be provided to you.

Reeves-Sain gives you three ways to pay for your monthly remaining balance (i.e. copays, non-covered items, over-the-counter, etc). Please choose which option works best for you by checking the box to the left of the payment option (1) Credit Card (2) Automatic Draft (3) Bill Me and complete the purchase agreement information.

1. Paying by Credit/Debit Card Visa Master Card Discover American Express

Credit Card Number: Credit Card Debit Card

Expiration Date: Month Year 3 or 4 Digit Security Code:

Your credit card will be charged on the 15th of each month for the balance due.

A monthly statement will be sent with your receipt attached.

2. Paying by Automatic Draft from Bank Account Voided check must be attached

Financial Institution Name _____ Type of Account: Checking Savings

Your checking account will be drafted on 20th of each month for the balance due.

A monthly statement will be mailed once the draft has cleared.

3. Paying by Monthly Statement (Bill Me)

You will receive a monthly statement itemizing charges that were not paid by your insurance.

Pharmacy Purchase Agreement

I agree to the following regarding all purchases:

1. I will pay the entire amount due within 30 days of the statement date shown on the monthly billing statement.
2. I agree to pay any charges not payable by any insurance source.
3. If the balance is not paid in full I will be assessed a service charges of 1.8% per month (21.6% per annum) and if not paid timely I could incur collection fees.
4. I authorize the facility personnel to make purchases on behalf of the named Resident.
5. I understand that if this account becomes past due it could potentially result in a disruption of pharmacy services, and/or incur collection fees.
6. I understand that I must notify Reeves-Sain Extended Care of any changes of insurance, address, phone number, etc.
7. I understand that this document must be on file in order for the pharmacy to provide any medications or other necessities to the Resident.

Signature of Responsible Party (Guarantor) Print Name Date

Patient/Resident Name Facility

Guarantor Address Guarantor Home Phone Guarantor Cell Phone

City, State, Zip Code

Relationship to Resident Closest Relative not living with you Phone