126 East City Center
St. George, Utah 84770
Phone: 435-703-CARE
Fax:435-703-2274

Agreement for Services **please allow 48-72 Business hours for first order**

Stapley Pharmacy provides services including, but not limited to, medical supplies, medications, blister card and Stapley packaging. The following agreement must be completed, signed, and returned prior to service. Stapley Pharmacy will bill all appropriate agencies/insurances when applicable and provided. The resident or guarantor will be responsible for any non-covered charges and co-payments, prior to medicine being dispensed.

Resident Information (please print) **Facility:** _____

Name: _____ Male ( ) Female ( )

Mailing Address_____zip code _____

Physical Address _____zip code_____

Date of Birth:_____ SSN:_____-_____-_____ Allergies:_____

Billing Status and Insurance Information: (please fill in all spaces that apply)

Medicare ID # _____

Primary Insurance Company: _____Phone: _____

Name on Policy (if not resident): _____Relationship: _____

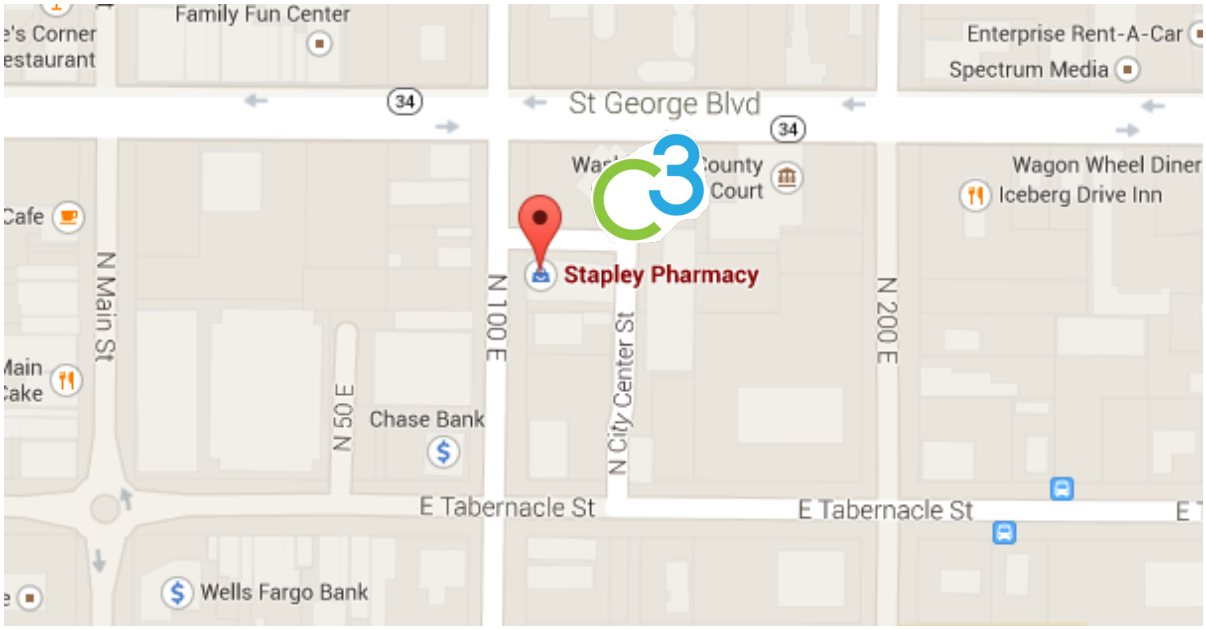
Prescription Insurance information

Rx ID Number: _____ Rx Group Number: _____

BIN Number: ___ ___ ___ ___ ___ ___ PCN:_____

Please attach a copy (both front and back) of ALL prescription insurance cards

ALL CORRECT INSURANCE INFORMATION MUST BE PROVIDED OR RESPONSIBLE PARTY WILL BE BILLED CASH PRICES



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Guarantor Information (Responsible Party for resident)

Name:_____ Date of Birth:_____ Relationship:_____

Address:_____City:_____State:___ Zip:_____

SS# (if out of UTAH) _____-_____-_____ Phone _____

Method of Payment ****REQUIRED**** (circle one) Visa MasterCard Discover AMEX

CardNumber:_____Expiration:_____CVV:_____

Cardholder's Signature: _____ Zip Code _____

Authorized Transaction: To allow for the payment for the medicine prescribed to be charged to the credit card listed above as approved by the facility and/or Guarantor. Stapley Pharmacy reserves the right at any time to discontinue service to the resident for any account with a past due balance, or a lack of funds. I understand that medications will automatically be dispensed and delivered. I agree that should the resident be discharged from the facility, it is my responsibility to notify Stapley Pharmacy. And satisify any debts remaining. If medication is delivered to the facility after discharge and is not refused at the time of delivery, it cannot be returned for credit. I agree to be responsible for payment of these medications. And all deliveries from the pharmacy on the residents behalf.

Guarantor signature: _____ Date: _____

(Signer must be the same as the Guarantor listed above)

Witnessed by (print) _____& sign_____

Please return the completed form to a member of your resident's staff or the pharmacy directly or email c3@stapleypharmacy.com

I, the undersigned, agree to pay for the individuals listed above, all costs associated with the provision of prescriptions or other goods or services from Stapley Pharmacy. I am providing a credit/debit card number for the Pharmacy to bill me for the excess costs and the medications or I will pay by check or other means. I authorize Stapley Pharmacy to process and charge my credit card for any balance that I may owe them. I, the undersigned patient, or responsible person for the patient, agree that I will be financially responsible for any co-pay, cost, and any non insurance covered costs. It is further understood that I will be billed monthly by Stapley Pharmacy and that my payment is due within 30 days of the mailing of my monthly statement by Stapley Pharmacy. If I fail to pay at the end of 30 days, I agree to pay interest on any unpaid balance in the amount of 1.5% per month together with any Attorneys fees, Court costs, service costs and a 50% collections fee for all unpaid balances that are turned over to a Law Firm or Collection Agency for collections. I understand that those items that are turned over to a law firm or collection agency by Stapley Pharmacy are in their sole discretion. Stapley Pharmacy will not turn over any accounts until the expiration 30 days from the mailing of a statement tome. I further agree to notify Stapley Pharmacy of any changes in my name, address, or credit/debit card information as stated above.

X_____

Patient/Resident name Print Signature Date

X_____

Responsibility/Guarantor Print Signature Date