



THE TERRACES AT SKYLINE



Dear Resident and/or Family Member,

We are excited to introduce CONSONUS PHARMACY SERVICES as our preferred pharmacy provider.

We have researched the current pharmacy providers in the area and have chosen to partner with CONSONUS PHARMACY to provide Medication Management services to our residents as they will:

- ✓ Provide a safer color coded packaging system for our residents' safety;
- ✓ Provide a consultant pharmacist as well as a nurse consultant to audit and make recommendations on medication or therapy at no additional charge to your loved one;
- ✓ Deliver emergency medications 24 hours a day, 7 days a week at NO additional charge;
- ✓ Competitive pricing – co-pays for Medicare Part D should match co-pays paid at local pharmacies;
- ✓ Low minimum price of \$4.99 for a 30 day supply of bubble packed common OTC's (i.e. Tylenol, Doss, vitamins, etc.)

Enclosed is a packet of information regarding CONSONUS PHARMACY services. We are requesting each resident sign and return the enclosed forms or waiver. The following forms are enclosed:

- ✓ **Form #1** Customer Agreement – Complete if your pharmacy of choice is CONSONUS PHARMACY.
- ✓ **Form #2** Pharmacy Waiver – Complete only if you elect **NOT** to use CONSONUS PHARMACY.

While every resident has the right to choose their own pharmacy, we encourage you to utilize CONSONUS PHARMACY. If you choose not to use this preferred pharmacy, we will charge a fee for coordination of this service on the negotiated service plan. We will require all medications to be in bubble packs, as we are confident this is the safest system to reduce the potential for medication errors. We understand that some pharmacies will charge for this added service, CONSONUS PHARMACY does not. As CONSONUS PHARMACY provides a safe, cost effective alternative for your loved one, please consider choosing this pharmacy as it will help our medication management program at The Terraces at Skyline run as safely and efficiently as possible.

If you have any questions, please contact CONSONUS PHARMACY at 425-869-2306.

Thank you,

CONSONUS PHARMACY and **THE TERRACES at SKYLINE**



CONSONUS
PHARMACY SERVICES
Customer Agreement

Resident Name: _____ Facility: _____

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- Consonus, or its affiliates, are authorized to provide me with all medications, pharmaceutical supplies and services that I may ask them to provide on my behalf.
- I am responsible for the payment of any medications, pharmaceutical supplies and services provided to me by Consonus. Payment is due upon receipt of Consonus statement and a finance charge will accrue on all delinquent amounts at an annual rate of 1.5% per month or the maximum annual rate permitted by applicable laws. The contingency fee assessed by any collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.
- I agree to pay all costs of collection, including court costs and attorney's fees, for all delinquent balances.
- I understand that all medications furnished are not packaged in child-proof containers.
- I consent to the release of all personal and medical information to any third party payor, governmental agency providing benefits, or other person(s)/ entity liable for my treatment charges. I consent to a similar release of information, as shall be necessary to initiate and continue my use of pharmacy services.
- I request that payment of authorized Medicare and or Private Insurance/Medigap benefits be made to Consonus Pharmacy on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.
- For the complete Privacy Practices policy please visit our website at www.consonushealth.com located under Pharmacy tab and select Policies.

Resident or Responsible Party: _____ Phone _____

I am the: Power of Attorney Guardian Responsible Party Conservator

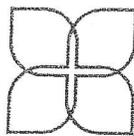
Billing Address:

Resident/Responsible Party Signature: _____ Date: _____

If this patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by the representative's name, address.

PO Box 22439, Portland, OR 97269-0439
14729 NE 87th St Redmond, WA 98052
2148 Beechcraft Vacaville, CA 95688

Phone: 971-206-5205 or toll free (877)311-1499 Fax: (877)728-8799 www.consonushealth.com



CONSONUS
PHARMACY
PROVIDER WAIVER

Residents in care facilities have a choice of which pharmacy they would like to use to deliver their medications. The medications must be dispensed in tamper-proof unit of use packaging that is compatible with the facility's established drug delivery system. The unit of use (bubble pack card) is designed to improve accountability, minimize tampering and decrease the risk of administration error in care facilities.

I, _____, assume the responsibility to obtain medications packaged in a
Resident/Responsible Party

modified unit dose (bubble pack) for: _____ at _____
Resident *Facility Name*

The pharmacy of my choice is: _____

All medications must be delivered in advance to the facility. Medications must contain the manufacturer and expiration date on the packaging to comply with federal regulations.

The care facility, as required by law, must obtain medications for the resident/patient timely. If I am unable to supply medications for the above resident I agree to pay Consonus Pharmacy Services for the cost of medication plus an emergency service fee of \$35.00.

I understand that Consonus Pharmacy Services is responsible only for its own pharmaceutical services and not those of my provider pharmacy. This includes drug parameters such as quality, quantity, storage, handling, labeling, etc.

Disclosure of Use of Patient Information for Treatment, Payment and Healthcare Operations. The patient or legal representative hereby authorizes Consonus Pharmacy, its employees, agents and sub-contractors to disclose to the Medicare or Medicaid programs or to any other third party payer any medical or other information needed for payment for all products and services provided by Consonus Pharmacy to the patient until payment has been made in full. The patient or legal representative further authorizes Consonus Pharmacy, its employees, agents and sub-contractors to use and disclose the Patient's medical and other information for the provision of the products and services, for the business operations of Consonus Pharmacy and for the review of Consonus Pharmacy's services, including review by accrediting bodies or governmental agencies. For the complete Notice of Privacy Practices please visit our website at www.consonushealth.com located under Pharmacy tab and select Policies.

Resident/Responsible Party Signature

Date

Print: Resident/Responsible Party

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