ACS Advanced Care Scripts

SERVICE AGREEMENT

TERMS & CONDITIONS

PATIENT NAME: _____ **D.O.B.**____/____/_____

In exchange for Advanced Care Scripts, Inc.'s agreement to (i) provide me with my medications/supplies; and, (ii) bill my insurance carrier or third party payor that is obligated to pay for my medications/supplies, I agree to the following terms and conditions;

1. **AUTHORIZATION FOR MEDICAL TREATMENT:** I authorize Advanced Care Scripts, Inc, under the direction of my physician, to provide my medications to me. I have been instructed by my physician about my prescribed medications and understand the reasons why they are considered necessary, their risks, advantages, possible complications and alternatives. As in any medication therapy, I understand that there are unknown risks as well as known risks. I certify that no guarantee or promise, expressed or implied, has been made to me in conjunction with the medications that have been prescribed for me.

2. **FINANCIAL RESPONSIBILITY:** I understand and agree that I am responsible for the payment of any and all sums that may become due for the medications provided to me by Advanced Care Scripts. If, for any reason and to whatever extent, Advanced Care Scripts does not receive payment from my insurer or third party payor that is obligated to pay for my medications, I do hereby agree to pay Advanced Care Scripts directly for the unpaid balance within thirty (30) days of receipt of an invoice from Advanced Care Scripts except in cases where such payment to Advanced Care Scripts is prohibited by applicable law. If my insurer and/or third party payor that is obligated to pay for my medications issues payment directly to me, I agree to promptly endorse such payment to Advanced Care Scripts and forward it directly to Advanced Care Scripts on the day that I receive such payment.

3. **UNPAID INVOICES:** I agree that any amounts that I owe to Advanced Care Scripts for more than thirty (30) calendar days, shall bear interest from the due date of such invoice, at the lesser of, one and one-half percent (1-1/2%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs and expenses of Advanced Care Scripts' collection efforts, including reasonable attorney's fees and court costs that are incurred by Advanced Care Scripts to collect overdue accounts.

4. **ENTIRE AGREEMENT:** This Agreement contains the entire agreement of the parties. No other representation, promise, or agreement, oral or otherwise, expressed or implied, not embodied herein, shall be of any force or effect. All amendments must be in writing and signed by both parties to have any effect. This Service Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors, heirs, and assigns.

***I have read and understand the above terms and conditions and agree to be bound by each of them:

Patient Signature: _____ Home Address: _____

Print: _____ City:_____State: _____Zip: _____

Date: _____

Or:

Legal Guardian on behalf of: _____

Signature:_____ Home Address: _____

Print: _____ City:_____State:_____Zip: _____

Date:_____

Relationship to Patient:_____(Please attach power of attorney or other proof of authority to sign on behalf of patient)