



# OMNICARE, INC.

## Patient Admission Record and Acknowledgment of Financial Responsibility

# Omnicare

Admission Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Patient SSN: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Male or Female: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Room #: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_

**Power of Attorney or Guardian, (Please circle One)**

Responsible Party: \_\_\_\_\_  
 Responsible SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, ST, ZIP: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_  
 Home Number: \_\_\_\_\_

**New Admission to  
The President Madison Inn**

Resident's CURRENT / PRIMARY Payor Status:

Medicare A # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Private Pay \_\_\_\_\_

Medicare B # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance \_\_\_\_\_

Other (Circle One) **Veteran/Hospice/Worker's Comp**

**(please include copies of all cards - front and back)**

Resident's SECONDARY Payor Status:

Medicaid # \_\_\_\_\_

Private Pay \_\_\_\_\_

Insurance \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Other (Specify) \_\_\_\_\_

**(please include copies of all cards - front and back)**

Authorization Agreement for EFT Account Payments (Where Applicable)

Cash \_\_\_\_\_ Exp Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

MasterCard # \_\_\_\_\_ Exp Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Visa Account # \_\_\_\_\_ Branch \_\_\_\_\_

Depository Name City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

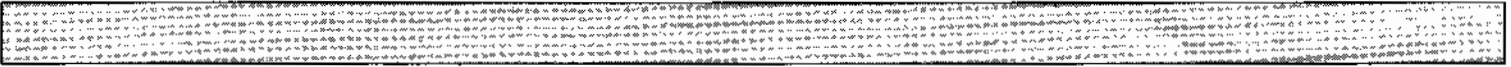
**This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.**

Patient/Resident Name: \_\_\_\_\_ Responsible Party Name: \_\_\_\_\_

(Printed) (Date) (Printed) (Date)

Patient/Resident Signature: \_\_\_\_\_ Responsible Party Signature: \_\_\_\_\_

(Signature) (Date) (Signature) (Date)



Resident's STATUS CHANGE Form:

Medicare A # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Private Pay \_\_\_\_\_

Insurance \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Other (specify) \_\_\_\_\_

**(please include copies of all cards - front and back)**

Resident's SECONDARY Payor Status:

Medicaid # \_\_\_\_\_

Private Pay \_\_\_\_\_

Insurance \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Other (Specify) \_\_\_\_\_

**(please include copies of all cards - front and back)**

1. **Authorization.** Omnicare hereby is authorized to provide me with all medications, pharmaceutical supplies and services that I may need.

2. **Payment.** I am responsible for the payment when due for all medicines, pharmaceutical supplies and services provided to me by Omnicare. Payment is due within 30 days of Omnicare's statement and a finance charge will accrue on all delinquent amounts at an annual rate equal to the lesser of 1.5% per month or the maximum annual rate permitted by applicable law.

3. **Power of Attorney.** I hereby make, constitute and appoint any officer or agent of Omnicare as my true and lawful attorney-in-fact, with power to endorse my name on any notes, checks, drafts, money orders or other instruments of payment that may come into the possession of Omnicare in full or part payment of any amounts owing by me to Omnicare. This power of attorney is coupled with an interest and is irrevocable.

4. **Records.** I hereby authorize Omnicare to submit to any HMO, PPO, Insurance provider or other third-party payer any of my medical and financial records, which Omnicare determines, is necessary or desirable to obtain payment for any amount owing by me to Omnicare.

5. **Further Assurances.** I hereby agree to execute upon Omnicare's request any other documents which Omnicare may request to further evidence any amounts owing by me to Omnicare (Including, without limitation, one or more promissory notes) and to provide collateral to secure the payment of such amounts.

6. **Termination of Service.** I acknowledge and agree that Omnicare has the right to suspend or terminate service if my account is delinquent.

7. **Fees & Expenses.** I also will pay all costs and expenses incurred by Omnicare in the enforcement of its rights under this Agreement including, without limitation, attorney's fees, court costs and expenses.

8. **No Modifications.** No modification or amendment of this Agreement, or consent to any departure by me there from, will in any event be effective unless the same is in writing and signed by Omnicare.

9. **No Waiver.** No delay or omission by Omnicare in exercising any right hereunder shall operate as a waiver of such right or any other right under this Agreement and a waiver on any one occasion shall not be construed as a bar to or waiver of any right on any future occasions.

10. **Binding Effect.** This Agreement will be binding upon my heirs, executors, administrators, successors and assigns.

\_\_\_\_\_

**Medicare Assignment of Benefits & Release of Information Lifetime Authorization**

**"I request that payment of authorized Medicare and or Private insurance/Medigap benefits be made to (Omnicare/supplier) on my behalf.. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and it's agents any information needed to determine these benefits or the benefits payable for related services."**

\*\* "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 "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign."

Representative \*\*

**Representative's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Reason** \_\_\_\_\_

Patient/Resident  
Name: \_\_\_\_\_  
(Printed) (Date)

Responsible Party: \_\_\_\_\_  
(Printed) (Date)

Patient/Resident  
Signature: \_\_\_\_\_  
(Signature) (Date)

Responsible Signature: \_\_\_\_\_  
(Signature) (Date)

