Pharmacy Consent/Payment Form

□ **Med Mgmt**
□ **Independent Living**

A&E Pharmacy (A&E) is hereby authorized to provide pharmaceutical services and related supplies for the Patient identified below. A&E will maintain a current medication profile on the Patient and provide free delivery services. A&E will provide pharmaceutical services and related supplies on an open account and will bill Patient's insurance as appropriate. If Patient's insurance does not pay in full, Patient guarantees payment to A&E for all pharmaceutical services and related supplies purchased from A&E. I authorize any holder of medical and/or insurance information about the Patient to disclose such information to A&E. I authorize A&E to disclose any medical and/or insurance information concerning the Patient in its possession: (1) to other professional personnel involved in Patient's care such as a physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payor who may be responsible for payment or pharmacy services.

Insurance and Billing Information

Patient Name: _____ Room #_____

Date of Birth: _____ Medicare ID # or SSN #: _____

Patient's Rx Insurance: _____ Phone of Insurance: _____

Bin#: _____ PCN: _____

ID #: _____ Group #: _____

Patient Representative (if any) (Print): _____

Patient Representative relationship to Patient: _____

Invoices will be sent to (check one and complete information): ☐ Patient ☐ Patient Representative

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Alt Phone: (_____) _____

Allergies: _____

I authorize A&E to request on Patient's behalf all public and private insurance benefits for pharmaceutical services and related supplies provided by A&E. I further authorize payment for such services and supplies to be made directly to A&E.

_____ _____
Signature of Patient or Patient Representative Date

Please initial:
___ I understand that A&E Pharmacy can provide a maximum one-month supply, and that I or my representative is responsible for ordering any refills that I need.

Previous Pharmacy: _____ Pharmacy Phone #:_____

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