PHARMACY
Custom Compounding Specialists

New Patient Intake Form

Name: **DOB:**

_____ _____/_____/_____
LAST FIRST MM DD YYYY

Patient Phone Number: (____)_____ Patient home zip code:_____(For insurance purposes)

Patient is: ☐ Cash client ☐ Has insurance (please choose one)

*Please include the credit card authorization form for payment of medications and/or co-pays

Gender: ☐ M ☐ F (please choose one)

Social Security#:_____ E-mail:_____

Primary Physician (during stay at facility):_____,_____
LAST FIRST

Smoker? ☐ Y ☐ N (please choose one)

Insurance provider:_____ tKI·ℕY I·ǒè I ŜfLJπŘŜǎ⅂#:_____
Usually a toll-free # found on the back of the card

wÈBIN#:_____ wÈPCN#:_____

ID#:_____ wÈGroup#:_____

Relationship to Subscriber:_____(e.g. father, child, spouse)

Please list any allergies:

_____

Intake Coordinator:

Please attach a Photocopy of patient's ID & Insurance Card **on one page**. Please attach the signed and dated HIPAA form. If patient will be paying for any services please include the signed and dated Credit Card Authorization Form. Failure to comply will result in delays or interruptions in services. Fax all documents together to (949) 429-5328. Please use the check-list below to ensure all necessary documents are included:

- ☐ Copy of ID
- ☐ Copy of Insurance Card
- ☐ HIPAA form
- ☐ Credit Card authorization form

31654 Rancho Viejo Road, Unit N, San Juan Capistrano, CA 92675 Phone: (949) 429-5326 Fax: (949) 429-5328
info@ocpharmacy.net
www.ocpharmacy.net

Facility
Name:_____

Credit Card Authorization

PHARMACY
Custom Compounding Specialists
31654 Rancho Viejo Rd. Unit N
San Juan Capistrano, CA 92675

Client Info:

_____ _____

LAST NAME FIRST DOB

CARD HOLDER INFORMATION:

Name:_____ Number: ( )_____ Fax: ( )_____
EXACTLY AS IT APPEARS ON CARD. Please print clearly

_____

BILLING: STREET ADDRESS CITY STATE ZIP

PLEASE SELECT CARD TYPE:

☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

±ACCOUNT #/CREDIT CARD # : _____

EXPIRATION DATE: _____/____
(MM / YY)

VISA/MASTERCARD

CVV2/VCODE:_____
THIS NUMBER IS A 3 DIGIT SECURITY NUMBER FOUND ON THE BACK-RIGHT OF THE CARD

AMEX

SECURITY #:_____
THIS NUMBER IS A 4 DIGIT SECURITY CODE FOUND ON THE TOP RIGHT OF THE FRONT OF THE CARD

DISCOVER

CVV2/VCODE:_____
THIS NUMBER IS A 3 DIGIT SECURITY NUMBER FOUND ON THE BACK-RIGHT OF THE CARD

Special Req:

I have read, completed, and understand the above agreement. I agree to have my card on-file at OC Pharmacy™. I approve of all charges for services rendered by OC Pharmacy™, and I agree to these terms and charges. **All charges are final. OC Pharmacy™ does not accept returns.** Please note: if this facility requires blister (bubble) pack dispensing, an additional $5 service fee will be charged per blister pack sheet.

±A $1.00 charge will be made to your card and subsequently refunded if your card is valid and working.

_____ _____

CARD HOLDER SIGNATURE DATE

OC PHARMACY HIPAA DISCLOSURE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We understand that your medical information is personal. We are committed to protecting your medical information. OC PHARMACY is required by law to maintain the privacy of your protected health information ("PHI"), to follow the terms of this Notice, and to give you this Notice of our legal duties and privacy practices concerning your health information. We must follow the terms of the current Notice.

How OC PHARMACY May Use or Disclose Your Health Information

OC PHARMACY protects the privacy of your health information. For some activities, we must have your written authorization to use or disclose your health information. However, the law permits OC PHARMACY to use or disclose your health information for the following purposes without your authorization:

For Treatment — We may use your PHI to dispense prescriptions to you. We may disclose your PHI to treating physicians, pharmacists and other persons who are involved in dispensing your prescription. For Payment — We may use and disclose your PHI so that your pharmacy services may be billed to, and payment collected from you, your insurance company or a third party. For Healthcare Operations — We may use and disclose your PHI for pharmacy operations, which include activities necessary to run the pharmacy, and to make sure that you receive quality customer service. For Prescription Refill Reminders and Health-Related Products and Services — We may use or disclose your PHI for prescription refill reminders, to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you. Individuals Involved in Your Care or Payment for Your Care — We may disclose your PHI to a family member or friend who is involved in your medical care or payment for your care, provided you agree to this disclosure, or we give you an opportunity to object to the disclosure. If you are unavailable or are unable to object, we will use our best judgment to decide whether this disclosure is in your best interests. As Required by Law — We will disclose your PHI when required to do so by federal, state or local law. To Avert a Serious Threat to Health or Safety — We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Lawsuits and Disputes — If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice), or to obtain an order protecting the information requested.

Specialized Government Functions — We may disclose your PHI (1) if you are a member of the armed forces, as required by military command authorities; (2) if you are an inmate, or in custody, to a correctional institution or law enforcement official; (3) in response to a request from law enforcement, under certain conditions; (4) for national security reasons authorized by law; and (5) to authorized federal officials to protect the President, other authorized persons, or foreign heads of state.

Workers' Compensation — We may disclose your health information for workers' compensation or similar programs.

Incidental Disclosures at the Drive-Thru Window — In some locations we offer a drive-thru window. A conversation with the pharmacy might be overheard by someone in or near the pharmacy. If you would like additional privacy, we suggest you conduct any pharmacy transactions within the store.

Personal Representatives — We may disclose your PHI to a person legally authorized to act on your behalf, such as a parent, legal guardian, administrator or executor of your estate, or other individual authorized under applicable law.

Other Uses and Disclosures of Your Health Information

Except as described in this Notice, we will not use or disclose your PHI without your written authorization. If you do give us authorization to use or disclose your PHI, you may cancel your authorization in writing at any time. If you cancel your authorization, this will stop any further use or disclosure for the purposes covered by your authorization, except where we have already acted on your permission. Please refer to the State Law Supplement for any stricter state laws regarding your PHI. If your state is not listed, its laws are not stricter than the federal privacy law.

You Have the Following Rights With Respect to Your Health Information in Our Records:

You may request restrictions on the use or disclosure of your PHI for treatment, payment or healthcare operations, or when using or disclosing your PHI to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request except in certain emergency situations or as required by law.

You may inspect and copy your pharmacy records, with certain exceptions. Usually, this includes prescription and billing records. We may charge you for the costs of your request. We may deny your request in some circumstances, in which case, you may request that the denial be reviewed.

You may request that we amend your health information if it is incorrect or incomplete. You must provide a reason that supports your request. We may deny your request if the health information is accurate and complete, or is not part of the health information kept by or for OC PHARMACY . If we deny your request, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request this, it will become part of your medical record. We will attach it to your records and include it when we make a disclosure of the item or statement you believe to be incomplete or incorrect.

You may request an accounting of disclosures of your PHI. This is a list of the disclosures made of your health information, other than for treatment, payment or health care operations, and other exceptions allowed by law. Your request must specify a time period, which may not be longer than six years and may not include dates before April 14, 2003.

You may request that we contact you in a certain way or at a certain location. For example, you may request we contact you only at work or at a different residence or post office box. Your written request must state how or where you wish to be contacted. We will grant all reasonable requests.

If you would like to exercise any of these rights, contact the pharmacy location that provided your services to get the appropriate form, or submit a written request to OC PHARMACY , HIPAA Privacy, ~PharmacyAddress~. A paper copy of this Notice may be obtained from OC PHARMACY upon request, or Changes to this Notice of Privacy Practices. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you and any information we receive in the future. We will post a copy of the current Notice in the pharmacy. If we change our Notice, you may obtain a copy of the revised Notice by Asking any of our staff.

Patient Name: _____

Patient Siganture:X_____