Louis & Clark Pharmacy

155 Brookdale Dr. 1st Floor • Springfield, MA • Office #: 413-781-2996 • Fax #: 413-737-0693

Thank you for choosing Louis & Clark Pharmacy to fill your Medication Prescriptions.
We take great pride in safety and helping you stay adherent to your Medication.

Patient Information:

First Name: _____ Last: _____ DOB: _____

Address: _____
Street City State

Room or Apt #: _____ Phone #: _____

Social Security #: _____ Male: _____ Female: _____

Drug Allergies: _____

Previous Address: _____

Independent: ____ Facility: ____ Group Home: ____ Facility/Group Name: _____

Referred By: _____ Phone #: _____

Prescription Insurance(s): (Attach a legible copy of all cards/both sides) Medicare #: _____

1. Primary: _____ **2. Secondary:** _____

Card #: _____ Card #: _____

Group ID: _____ Group ID: _____

Bin #: _____ PCN #: _____ Bin #: _____ PCN #: _____

Prescriber Information:

Primary Care Physician Name: _____ Phone #: _____

Address: _____

- *May we contact your previous pharmacy if we have questions?* YES / NO
  Previous Pharmacy: _____ Phone #: _____

Please indicate all your Preferences:

_____ **MediBubble** (28-day multi-dose packaging)

- Do you prefer PRN (as Needed) medications in: _____Vial **OR** _____ Blister Pack?

Initial here _____ to acknowledge that you understand that MediBubble is non-safety packaging.

_____ **Blister Pack** (30-day unit dose packaging)

_____ **Vial Synchronization** (28-day vial)

_____ **Pickup *OR*** _____ **Delivery**: If Delivery, please note any special instructions: _____

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House Charge Application

Patient Name: _____ DOB: _____

Patient Phone #: _____

Patient Driver's License #: _____ State: _____

Facility Address: _____
Street City State

*Delivery Address: _____
*(*If Different)* Street City State

Person Paying Bill and Address to which it should be Mailed:

Name: _____ Relationship: _____

Care of: _____

Address: _____

Phone #: _____
Cell Phone Home Phone Work Phone

_____
Signature of Resident OR Responsible Party Date of Agreement

Authorization for Automatic Payment to Credit Card as charges are incurred:

Please charge my: VISA: _____ MASTERCARD: _____

Card Number: _____

Expiration Date: _____/_____/_____

Card Security Code (3 digits # on back of Credit Card): _____

Print Card Holders Name: _____

Authorization Signature: _____ Date: _____

Should the applicant fail to pay for services rendered, he/she shall be responsible for all sums due, plus cost of collection, including attorneys fees and interest

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: Louis & Clark Pharmacy Springfield, MA

A. Authorization I, the undersigned Patient, (or the Patient's Personal Representative) authorize the Pharmacy named above to disclose my **Protected Health Information ("PHI")** that is in the Pharmacy's possession or control to the Recipient named below strictly in accordance with the directions contained in this Authorization.

B. Re-Disclosure (*Delete whichever sentence does not apply.):* (1.) I understand the PHI disclosed pursuant to this Authorization may be re-disclosed by the Recipient, and that such re-disclosure may end my HIPAA PHI protection. (2.) This Authorization does not permit re-disclosure by the recipient.

C. Revocation I further understand that I have the right to revoke this Authorization in writing, in the form attached, but that any actions already taken in reliance on this Authorization will not be reversed and my revocation will not affect such actions.

D. Patient

Patient Name: _____ DOB: _____

Patient Phone #: _____

Address: _____
Street City State

E. Recipient - The PHI is to be disclosed to the following persons:

Name: _____ Relationship: _____

Phone #: _____
Cell Phone Home Phone Work Phone

Address: _____
Street City State

E-Mail: _____ Fax #: _____

_____

F. Description - The minimum necessary PHI to be disclosed is described as follows:

_____ Any information pertaining to patient's medication or medication therapy

OR (state limitations): _____

G. Duration This Authorization shall be in effect for as long as the patient is receiving pharmacy services unless sooner revoked in the manner described above.

_____

Signature of Patient or Patient's Personal Representative Date

Please describe the source of the Personal Representative's authority to sign for the Patient, e.g. Parent of an un-emancipated minor, or Parent in *Loco Parentis*; or if appointed as custodial Parent, Guardian, Executor, or Administrator and the like. Please attach copies of any documents of appointment.

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ACKNOWLEDGEMENT OF RECIEPT OFNOTICE OF PRIVACY PRACTICES

Our privacy practices require that we give you a copy of our Notice of Privacy Practices at the time of our first pharmacy service.

I acknowledge that I have received a copy of the Pharmacy's Notice of Privacy Practices.
To be signed by the patient or the patient's power of attorney.

_____

Patient / Power of Attorney Signature

_____

Patient / Power of Attorney Name Printed

Date_____