Advanced Prescription Services

3671 Broadway Blvd., Suite 300 Garland, TX 75043
Office: 214-703-9100 Fax: 214-703-9102

New Patient Form

Name: _____ Date of Birth: _____ M/F

Address: _____

Home Phone: _____ Cell Phone: _____

Drug Allergies: _____

Social Security #: _____

Prescription Insurance / Medicare Part D Name: _____

Rx Group #: _____ Rx BIN #: _____ Rx ID #: _____ Rx PCN #: _____

Name as it appears on Credit Card: _____

Card #: _____ Expiration: ___/___ 3-Digit Code: _____ Billing Zip: _____

Monthly Statement Requested: Yes or No

I voluntarily designate ***Advanced Prescription Services*** as my choice provider of pharmacy services effective on the date indicated. I agree to provide credit/debit card information to ***Advanced Prescription Services*** to charge any medication or purchases.

I agree to accept responsibility for and guarantee payment for all charges and for all services and supplies provided by ***Advanced Prescription Services***, which are not covered by third party payers including Medicare and Medicaid. The patient or the patient's family is responsible for medications requested by the facility on the patient's behalf. Any outstanding balances due after 30 days will be charged a finance charge of 1.5% monthly, which is an Annual Percentage Rate of 18%. I agree to pay all collection cost, court costs, reasonable attorney's fees, and taxes to recover any amount owed. I will notify ***Advanced Prescription Services*** in writing of my intent to cancel this agreement 30 days in advance.

I agree to the above terms and conditions as the responsible party. My signature authorizes any entity to release Medicare, medical and non-medical information, and whether the resident has insurance of any kind which is responsible to help pay for the services rendered. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient or resident is responsible only for the deductible, co-insurance, and non-covered services.

I understand that failure to comply with any or all of the above can result in medication not being delivered.

Responsible Party: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Billing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Drivers License #: _____ Relationship to Resident: _____

Signature: _____ Date: _____

If you are not the patient listed above, we will need a copy of the Power of Attorney to keep on file.

If you request a non-child-resistant container, you specifically agree and acknowledge that you release ***Advanced Prescription Services*** and its Pharmacists from any and all civil liability for not using the safety closure container.

Please Sign and Mail, Fax or Deliver to ***Advanced Prescription Services***