WALNUT HILL PHARMACY
1950 South Sycamore Street
Petersburg, VA 23805
Phone #: 804-733-7711   Fax#: 804-733-8819

INFORMATION FOR BILLING DEPARTMENT

DATE:________________

PATIENT NAME:____

FACILITY NAME:____

FACILITY/HOME ADDRESS:____

____

DATE OF ADMISSION TO FACILITY:______________________________________

DATE OF BIRTH:____

PAITENT'S SOCIAL SECURITY NUMBER:__________________________________

RESPONSIBLE PARTY*:____

RELATIONSHIP OF RESPONSBILE PARTY TO PATIENT:_____________________

PHONE NUMBER OF RESPONSIBLE PARTY:_______________________________

ADDRESS OF RESPONSIBLE PARTY (ADDRESS TO WHICH MONLTHY BILL WILL BE SENT):

____

____

I agree to take responsibility of all charges for ____.
If payment is not made, legal action will be taken. I will then be responsible for attorney's fees and court costs.

____
(Signature of Responsible Party)

*The responsible party is the person that is to pay the patient's monthly bill, including the $5.00 monthly packaging fee which is not covered by insurance. The contact information must be accurate, if we are unable to contact this party as billing questions arise or if payments are not made, medications will not be sent.

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INFORMATION FOR MEDICINE ON TIME DEPARTMENT

This form is to be accurately completed by a representative of the facility's staff before any medications will be issued to the patient.

Allergies (Please list all allergies to medications and the specific symptoms involved in the reaction):

____

____

Patients Prescription Insurance Information * (Please attach a copy of the card)

Type of Card:____

I.D. Number:____

Group Number (if applicable):________________________________

*We must be notified promptly if a patient's insurance information changes, failure to do so will hinder the packing of patient's medication(s) and will result in interruption of service.

Physicians Phone (Please list all current Physicians, Primary Care, Psychiatric, etc.):

____

____

Medications (Please list all current medications):

____

____

____

Note: It is REQUIRED that within 24 hours of a patient permanently leaving the facility or being admitted into the hospital that the pharmacy is notified by a facility representative.

________________________________ ________________________________

Printed name of Facility Representative Signature of Facility Representative

WALNUT HILL PHARMACY
1950 SOUTH SYCAMORE STREET
PETERSBURG, VA 23805
PHONE (804) 733-7711 FAX (804) 733-8819

INFORMATION FOR DAY SUPPORT PACKAGING PROGRAM

PATIENT NAME____

___________________**Yes, this resident requires Day Support Packaging**

(If yes, please initial and fill out the information below. If no, please initial and sign the bottom of the form)

Assisted Living Facility____

Day Support Program Name____

Hours of Operation____

(IMPORTANT: ANY MEDICATIONS SCHEDULED WITHIN THE TIMES LISTED ABOVE WILL BE SET FOR DAY SUPPORT PACKAGING. PLEASE LIST THE CORRECT TIMES THAT THE RESIDENT WILL ATTEND DAY SUPPORT.)

By signing below I am aware that Day Support Packaging is an additional $2.00 monthly packaging fee making the residents monthly packaging fee $7.00 ($22.00 if we repackage medications from another pharmacy for the resident).

I am also aware that if any of the information listed above changes the pharmacy is to be notified within 24 hours of the change(s). (Ex. Change in Day Support hours, Change in Day Support Program attended, etc.)

______________________________________ ______________________________________
(FACILITY STAFF MEMBER PRINTED) (FACILITY STAFF MEMBER SIGNATURE)

_________________**No, this resident does not require Day Support Packaging at this time.**

______________________________________ ______________________________________
(FACILITY STAFF MEMBER PRINTED) (FACILITY STAFF MEMBER SIGNATURE)