KENT STATION PHARMACY SCHOOL FORMS

38 North Main Street/Box 632 Kent, CT • (860) 927-3725 • Fax: (860) 927-3895 • info@kentstationpharmacy.com

Student Registration

To submit this form electronically, please download the PDF to your computer and open in Adobe Acrobat Reader. Please make sure you are using the latest version of Acrobat Reader.

Adobe Acrobat Reader is a free PDF reader that can be downloaded here: https://get.adobe.com/reader/

Parent/Student Information

Parent/Guardian Name:

Parent/Guardian Email:

Home Phone:	Cell Phone:	
Student's Name:	○ Male ○ Female	Date of Birth:

Street Address:

City:	State:	Zip:

School Name:

Prescription Insurance Information

Student Name:

Parent/Guardian or Insured Name:

Rx Member ID:

Rx BIN Number:	Rx PCN Number:	Rx Group:

Parent/Guardian or Insured Street Address:

City:	State:	Zip:

REMEMBER: *It is critical to forward us a copy of both sides of the insurance card of the parent/guardian and the patient. We are always available to answer any questions you may have at (860) 927-3725.*

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Credit Card Authorization Form

Parent/Guardian Credit Card Information

Card Type *(select one)*: ○ Visa ○ MasterCard ○ AMEX ○ Discover

Card Number:	Exp. Date:	Security Code:

Name on Card:

Billing Street Address:

City:	State:	Zip:

I acknowledge and assume responsibility and grant authorization for Kent Station Pharmacy to charge the above credit card for registration and sign-up fees where applicable. I also acknowledge responsibility for the cost of any medication not covered by my insurance company, for any medication that Kent Station Pharmacy cannot get reimbursement for, as well as any co-insurance and deductibles and charges for requested OTC products which I agree will be billed to my credit card by Kent Station Pharmacy. I authorize Kent Station Pharmacy to contact my insurance company for insurance verification, billing, and collections for my medications. As per our HIPPA agreement all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection. I understand that I am responsible for the costs of all medication changes received after a prescription has been filled or packaged.

Student Name:

Signature of Guarantor:	Date:

Please Print Name:

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Notice of Privacy Practices

Parents/Guardians: Please sign the following form after reviewing Kent Station Pharmacy's Notice of Privacy practices, which can be found at www.kentstationpharmacy.com.

Kent Station Pharmacy is covered by the medical information privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (generally called "HIPAA") and its Regulations. As a result, we are required to comply with HIPAA and the Regulations in the use and disclosure of health information by which our patients can be individually identified. We are also required under Section 164.520 to give our patients this notice (in paper or electronically as the patient wishes) of our legal duties and privacy practices concerning their Protected Health Information, and also to tell our patients about their rights under HIPAA and the Regulations. If you have any questions about our policies, please contact us directly. We are required by this Act to request your signature upon receipt of this document. Please sign your first and last name clearly on the line below. If your child is 18 or older, he or she may sign as an adult.

I have reviewed a copy of the Kent Station Pharmacy Privacy Notice.

Signature: Date:

Please print student name.

Student Name:

Email Form