

Poets Square Pharmacy

10 Thoreau Ave. Freehold, NJ 07728
(732) 409-1100

Camper Registration Form

Camper Name: Last: _____ First: _____ DOB: _____
Check One: () Male () Female **ALLERGIES:** _____
Responsible Party Name: _____
Responsible Party Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work Phone: _____
E-mail Address _____@_____
Insurance Information: Company Name: _____ Phone: _____
BIN# _____ PCN# _____ ID# _____ GROUP# _____

Drug Name	Strength	Directions	Time Given

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree registration fee will be billed upon receipt of this form.
- I agree that community personnel are authorized to order, purchase and charge on behalf of the above resident.
- I agree to provide the pharmacy with a photocopy of the front and back of the insurance cards used for prescription coverage.
- I agree to notify the pharmacy of any future changes in prescription coverage.
- I agree to notify the pharmacy of any future changes in address, E-mail address or credit card information.
- I agree that any medication that has been dispensed or discontinued cannot be returned
- I agree to pay all charges (i.e. prescriptions, prescription co-pays, and over the counter charges) incurred by myself or the above named camper not paid for by third party payees, including Medicaid.
- I agree to pay all costs of collection including court costs and attorney's fees, if necessary, in order for the pharmacy to collect any and all delinquent balances.

(Responsible Party/Guarantor)

(Date)

As a recurring transaction, you may charge (circle one) **Visa, Mastercard, Discover, AMEX**

Name of Credit Card Holder: _____

Address of Credit Card Holder: _____

Account No. _____ Expiration Date _____

3-digit code on back of card if it is AMEX it is 4-digit (**CVA #**) _____

(Signature)

(Date)