King's Daughters Pharmacy

1905 SW H K DODGEN LOOP, TEMPLE, TX 76502

PH# 254-778-1731 FAX#254-791-2266

Patient Registration Form:

Patient Name:_____ Date of Birth:_____

Sex: **M** **F** Allergies:_____

Home Address:_____ Phone#_____

City:_____ ZIP:_____ Alt Ph#_____

Social Security Number (optional):_____

*Allows us to locate insurance information for you in the event you are unable to present an insurance card

NAME OF GUARANTOR:_____

GUARANTOR CONTACT PHONE NUMBER_____

GUARANTOR ADDRESS:_____

Prescription Preferences:

Other information or special request(s):_____

_____

Current Pharmacy Name and telephone_____

Medication List and RX numbers you would like for us to transfer:

Thank you for choosing to fill your prescriptions with our Pharmacy. Please present your insurance card with this completed form to the pharmacy staff to aid us in processing your prescriptions efficiently. Our pharmacy is HIPPA compliant and maintains the confidentiality of your private healthcare information. Please sign and date below to confirm receipt of privacy practice disclosure and pharmacy registration.

Patient Signature:_____ Date:_____

---------- This space for copies of applicable insurance cards ----------

King's Daughters Pharmacy is a local Texas independently owned pharmacy provider. The pharmacy has proudly been helping Central Texas residents stay healthy since 1961. Effective May 11th, 2020 our pharmacy will be the Primary Pharmacy Services provider for Luvida Memory Care of Belton, TX residents. We accept all major insurance plans and will be providing delivery of all prescription medications orders. Our pharmacy processes prescriptions in your best interest and will attempt to provide medications at the lowest price possible including attempting to locate and utilize copay savings programs from manufacturers to reduce your final cost if eligibility requirements are met. We also offer over the counter medications and household supplies for purchase and free delivery that Residents may find convenient. Please supply your preferred method of payment, contact, and or billing information to provide us the opportunity to service your prescriptions. We will make every effort to contact the Guarantor on file for any ordered medications regimens we receive with high copayments or costs prior to charging or billing for services.

TO LUVIDA OFFICE: May fax this form with a face sheet including Name, Mailing Address, Date of Birth, Allergy information, & Contact phone numbers. Please confirm ADDRESS on file is a MAILING ADDRESS. (if not please send alternate mailing address w/face sheet & copies of cards.) Alternately may have the patient complete the Patient Enrollment form in place of sending a face sheet.

Method of Payment: (Circle one)

Credit Card **Monthly Bill**

VISA **MC** **DISCOVER**

Card Number_____ **EXP**_____

Name on Card_____ **Sec Code**_____

Billing ZIP Code_____

Notification Options: (Circle one) No Limits Call if Copays over $45 Call if copay over $100

This form provides pharmacy necessary information to maximize the convenience of pharmacy services for you and your family. Please sign to authorize the agreement for pharmacy services by King's Daughters Pharmacy and fax completed forms to pharmacy as soon as possible. Thank you.

Patient/Signature **X**_____ Date_____

Fax completed forms to (254)791-2266 **For Questions call (254)778-1731**