MEDICAL ARTS PHARMACY

2102 Pecos Street San Angelo, TX 76901
Phone: 325.949.5381 Fax: 325.942.9997 Email: map@medicalartspharmacy.net

Pharmacy Store Charge Agreement

Resident Information:

Name:_____ Gender: Male Female

Date of Birth: _____ Social Security #: _____

Allergies: _____

Responsible Party/Power of Attorney Information (if applicable):

Name: _____ Phone #: _____

Address: _____

City: _____ State:_____ Zip: _____

Email address: _____ Cell Phone: _____

Relationship to patient: _____

Prescription Insurance Company: (Please include copies of the front and back of all insurance cards)

Insurance Company name: _____ Phone: _____

ID#: _____ Rx Group: _____

Rx Bin: _____ Rx PCN: _____

Previous Pharmacy Information:

Name: _____ Phone: _____ Fax: _____

By signing this agreement, I (we), the undersigned person(s) voluntarily agree:

1. That Medical Arts Pharmacy is my pharmacy services provider of choice effective on the date indicated by my signature below;

*CONTINUED ON BACK

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2. To provide Medical Arts Pharmacy with my current prescription insurance information prior to the start of service, including a copy of (front and back) of any and all prescription insurance cards; I (we) agree to provide Medical Arts Pharmacy with any changes to my prescription insurance; and I (we) assume responsibility for any changes related to these changes;
3. Medical Arts Pharmacy is authorized to request and collect all insurance benefit information related to the products and services it provide; In the event any payment for insurance benefits is made directly to me or my attorney-in-fact, I (we) will immediately endorse and send such payment to Medical Arts Pharmacy;
4. To accept generic products, when available, as allowed by my physician and applicable law in an effort to contain costs;
5. To accept full financial responsibility and guarantee payment of all charges for pharmacy services provided by Medical Arts Pharmacy that are not covered by third party payers, including Medicare and Medicaid;
6. That Medical Arts Pharmacy cannot accept returns of medication that are not in compliance with the applicable State Board of Pharmacy rules and regulations; and
7. That this document and my financial responsibility will remain in effect until I (we) provide Medical Arts Pharmacy with written notice of my decision to terminate services with your company.

Most insurance companies do not allow us to back bill them after a limited period of time. If we do not receive your insurance card with this application, you will be required to pay for the prescription's full retail price and submit your receipt to your insurance company.

I have read, understand, and agree to all the above terms and conditions and voluntarily designate Medical Arts Pharmacy as my pharmacy services provider.

_____ _____

Responsible Party Signature Date