P4 PHARMACY WELCOME AND INFORMATION PACKET

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WELCOME TO P4 PHARMACY

The staff of P4 Pharmacy would like to welcome you! We are excited to provide service for you and/or your loved one. P4 Pharmacy is a locally owned business based in South Jordan, UT. We are devoted to the care of our patients and all of their needs.

At P4 Pharmacy we provide services for patients of long-term care communities (i.e. assisted living, skilled nursing, rehabilitation, home health, and hospice). Services include, but are not limited to, consultation, immunizations, medications, delivery, and medical supplies.

P4 Pharmacy will work with you, your physician and your insurance company to ensure that your needs are met. We strive daily to go above and beyond to care for the complex needs of some of society's most fragile individuals. Thank you for this opportunity!

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

SSN#: _____ **Gender: M** ☐ **F** ☐ **Allergies:** _____

Primary Doctor: _____ **Doctor #:** _____

Move-in Date: _____ **Room #:** _____

Community Name: _____

Responsible Party (send statements to): _____

Street Address: _____

City: _____ **State:** ___ **Zip:** _____

Phone: _____ **email:** _____

(Email will be used only for delivery of monthly invoice)

Relationship to Patient: _____

Prescription Insurance #:_____

Rx Policy #: _____ **Rx BIN #:** _____

Rx PCN #: _____ **Rx Group #:** _____

Please attach a copy of both sides of the Insurance Card

If we are unable to bill insurance then the Responsible Party will be billed cash prices for all medication provided

PAYMENT AGREEMENT

P4 Pharmacy will bill all appropriate agencies/insurances when possible, but the resident/patient or responsible party is ultimately accountable for any and all non-covered charges and co-payments.

- Private Pay: P4 Pharmacy will bill the resident/patient or responsible party directly.
- Insurance: After insurance has been billed, the resident/patient or responsible party will be billed for all non-covered charges.
- Hospice: P4 Pharmacy will bill the hospice agency for all related charges. The patient or responsible party will be billed for all non-covered charges.

I, The individual specified below, agree to allow P4 Pharmacy to use the included credit card, bank account information or other method of payment to pay for pharmacy services as defined above. I understand that this information will be stored securely and that suitable measures will be taken by the pharmacy to protect this information.

_____ _____

Signature: **Date:**

(By signing this electronic signature I give my consent of following information above)

METHODS OF PAYMENT

Credit Card

Name on card: _____

Card #: _____ Exp. Date: _____

CVC/CVV #: _____

Billing Address (if different than above):

Street Address: _____

City: _____ State: ____ Zip: _____

ACH Payment

Name on Bank Account: _____

Banking Institution: _____

Account #: _____ Routing #: _____

We work hard to take care of your needs, even your financial needs. Please call ASAP if you need accommodations or special billing arrangements. Our billing department can be reached at 385-415-5868.

NOTICE OF PRIVACY PRACTICES/HIPAA

Please visit https://www.p4pharmacy.com/HIPAA for our full Privacy Practices.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Therefore, the Pharmacy pledges to protect your health information as required by law. We provide you with this notice of privacy to tell you how we will use and disclose your medical information. **PLEASE REVIEW IT CAREFULLY.**

Signature: _____ Date: _____

By signing this document I acknowledge that I have received the P4 Pharmacy Notice of Privacy Practices.