SIERRA SPECIALTY PHARMACY

9738 South Virginia St. #F • Reno, Nevada 89511
Tel: 775-853-3502 • Fax: 775-236-5771

Billing & Consent Form

Facility/Group Home Name: _____

Delivery Address: _____

Current Pharmacy Name, Location, and Phone Number: _____

Patient Information

Name: _____ DOB: _____ SS#: _____

Allergies & Diagnosis: _____

Primary Care Physician: _____

Billing Information

Name of Responsible Party: _____

Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card # of Responsible Party: _____

Expiration Date: _____ CVV/CID: _____

Responsible Party Email (If Available): _____

Prescription Insurance Information (Please Provide Copy of Insurance Card(s))

Insurance Name: _____ ID/Member #: _____

BIN#: _____ PCN#: _____ Group#: _____

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I have read, understand and accept the following terms and conditions:

I agree to have Sierra Specialty Pharmacy fill and coordinate the care of my prescriptions through medication packaging, and delivery. There is no charge for the packaging or delivery.

I agree to pay all charges incurred by the above-named patient that are not paid for by third-party payers, including Medicaid/Medicare, and additional charges for specially-packaged medications.

I will pay the entire amount within 25 days of the statement date shown on the monthly billing statement.

I agree that in order for the patient account to remain active, payment for billed charges must be made promptly pursuant to these terms.

I agree to pay all costs of collection, including court costs and attorney's fees for all delinquent accounts/balances.

I understand that the medications furnished to the above-named patient are not, and will not be, packaged in child-proof containers.

I consent to the release of personal and medical information to any third-party payer, government agency providing health/prescription benefits, or any other person/entity responsible for my treatment charges. I consent to the release of all information as shall be necessary to initiate and continue my use of pharmacy, laboratory, or other similar community resources and/or transfer to another health care facility.

I certify that the information contained in this application is true and correct. I authorize verification of any and all of this information to include a check of credit.

You have permission to charge my credit card monthly to pay my statement.

Signature of Responsible Party _____ Date _____