# Billing & Consent Form

FACILITY INFO: _____

Name Delivery Address

PHARMACY TO TRANSFER RX FROM: _____

Name Location Phone #

**Patient Information**

Name: DOB: SS#: Room#:

Allergies: _____

Diagnosis: _____

Primary Care Physician: _____

Name of Responsible Party: Relationship to Patient:

Home Phone: Cell Phone:

Billing Address: _____

City State Zip Code

Credit Card # For Billing: _____

Expiration Date: CVV/CID: Res Party Email (Optional):

**Prescription Insurance Information [Please Provide Copy of Insurance Card(s)]**

ID/Member #: BIN: PCN: RXGROUP:

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND I ACCEPT THE FOLLOWING TERMS AND CONDITIONS:**

I agree to have Sierra Specialty Pharmacy fill and coordinate the care of my prescriptions.

I understand that this form must be filled out entirely even if Sierra Specialty Pharmacy will not be providing medications so in the event of an emergency or change, they can service the patient.

I certify that the information provided is true and correct, and I authorize verification of any and all information.

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 the pharmacy.

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

I agree to pay the entire amount within 25 days of the statement date shown on the monthly billing statement. I understand that for the patient account to remain active and for the patient to continue receiving services, payment for billed charges must be made pursuant to these terms.

I agree that the provided credit card will be auto charged monthly on/about the 15th of the month for the prior month's statement.

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

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

SIERRA SPECIALTY PHARMACY
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