

FORM MUST BE COMPLETED AND RETURN PRIOR TO OPENING ACCOUNT
ATKINSON'S PHARMACY

CUSTOMER, CONTACT AND RESPONSIBLE PARTIES AGREEMENT

1994 Kingsley Ave, Orange Park, FL. 32073
Phone: 904-298-0873
E-mail: Laura_Cox@atkinsonpharmacy.com

Resident's Name _____ Male _____ Female _____
(Last) (First) (Middle)

Social Security # _____ D.O.B. _____ Facility _____

RESPONSIBLE PARTY:

Responsible Party: _____ () POA () Fin.Guar

Address: _____
(Street or P.O.Box) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

EMERGENCY CONTACT:

Emergency Contact: _____
(last) (first) (middle)

Address: _____
(Street or P.O. Box) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Relationship to Patient: _____

INSURANCE PROVIDER:

Prescription Benefits Provider: _____ I.D. # _____

Group #: _____ BIN #: _____ Proc Ctrl #: _____

Customer Service Phone Number: _____

Only co-pays, non-covered items will be charged to customer's credit card on file with the pharmacy.

*****PLEASE INCLUDE A COPY OF FRONT & BACK OF PRESCRIPTION DRUG CARD*****

Atkinson's Pharmacy will collect from insurance whenever benefits are available. If charges are denied Atkinson's will contact the customer or the Responsible Parties to authorize payment for services and goods provided before being delivered.

Resident and Responsible Party:

Contact and Responsible Party:

Print Name-Resident and Responsible Party

Print Name – Contact and Responsible Party

Signature – Resident and Responsible Party

Signature – Contact and Responsible Party

Date

Date