**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:

_____
Print Name-Resident and Responsible Party

_____
Signature – Resident and Responsible Party

_____Date

Contact and Responsible Party:

_____
Print Name – Contact and Responsible Party

_____
Signature – Contact and Responsible Party

_____Date