DRUG MART PHARMACY

1249 W. 7th Street
South Plainfield, NJ 07080

Patient Name: _____ Date of Birth: _____

Address: _____

Patient Document Acknowledgement:

I acknowledge receipt of the following patient documents:

☐ Welcome Letter ☐ Notice of Privacy Practices ☐ Patient's Bill of Rights

☐ Emergency Preparedness ☐ Proper Disposal of Medicines ☐ Complaint Procedure / Form

Preferred method of contact:

☐ Cell Phone: _____ ☐ Text: _____ ☐ Home Phone: _____

Authorization to Assign Benefits to Provider: I request that payment of authorized Medicare & other benefits be made on my behalf to Drug Mart for products & services that they have provided me. I further authorize a copy of this agreement to be used in place of the original & authorize any of medical information including medical records to be released to Drug Mart, as well as, any Federal, State or Accrediting Body or Agency as required by the Regulatory, Licensing or Accrediting Body, in order to determine these benefits or compliance with current healthcare standards. Drug Mart bills third-party as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowable, including charges related to delivery before the verification of insurance benefits.

Primary Insurance ID: _____ Group: _____ Effective Date: _____

Second Insurance ID: _____ Group: _____ Effective Date: _____

HIPAA Release: In accordance with the HIPAA Privacy Regulations, Drug Mart may disclose to a member of your family, other relative, or a close personal friend, or any other person identified by you, the protected health information directly relevant to such persons involvement with your care or payment related to your health care. Please assist us by identifying below individuals who are involved in your care and/or in the payment of your care to whom a limited amount of information may be released. If there are no such individuals, please indicate none.

PATIENT NAME (PLEASE PRINT)	PATIENT SIGNATURE	DATE

PATIENT'S AGENT OR REPRESENTATIVE (IF APPLICABLE)	RELATIONSHIP TO PATIENT (IF APPLICABLE)

Patient personal information will be kept confidential by Drug Mart. Patient must notify Drug Mart of nay medical status change such as a doctor's prescription, hospitalization, acquiring and infectious disease or change in residence. Patient agrees to notify Drug Mart of Advance Directives being in place and any changes thereof.