MY EASY Rx

Granite PHARMACY

With convenient locations in
Frenchtown, Libby, and Missoula.

PERSONAL INFORMATION

Today's Date: _____

Patient Name: _____ SS#: _____

Address: _____

Phone #: _____ Date of Birth: _____ Sex: M or F

Preferred method for receiving meds (please select one): ☐ Pick-up at the pharmacy ☐ Deliver to my house *(Missoula only)*

Notes/Comments: _____

MEDICAL INFORMATION

List All Known Drug Allergies: _____

_____

Primary Care Physician: _____

Previous Pharmacy (Name & City): _____

INSURANCE INFORMATION

Prescription Insurance Coverage No _____ Yes _____ (Please provide copy of card)
Medicare Coverage No _____ Yes _____ (Please provide copy of card)

AUTHORIZED HIPAA RELEASE

List below any other individuals that are authorized to receive information regarding your medications and/or charge accounts at Granite Pharmacy. A written Notice of Privacy Practice is available for review at your request.

1. _____
2. _____
3. _____
4. _____

CHARGE ACCOUNT

Patient Name: _____

Billing and Contact Information for Responsible Financial Party:

Name: _____
Address: _____
_____
Phone #: _____
Relationship to Patient: _____

****Optional** Preferred Methods of Payment:** All monthly statements will be sent at the first of the month. If you chose to use a preferred payment method, it will be billed around the 8th of each month.

Credit or Debit Card:
Card Number: _____ Exp: _____ CVV: _____

OR

Automatic Withdrawal from Checking Account: (Please attach Voided Check)
Routing Number: _____ Account Number: _____

Signature to authorize payment: _____

PAYMENT AND UNPAID BALANCES

Granite Pharmacy is committed to providing the best products and services possible for their customers at rates that are usual and customary for the area. Individual charge accounts are temporary and for your convenience, but they must be paid in full every 30 days **OR** finance charges may apply.

****PACKAGED MEDICATION CYCLES DO *NOT* MATCH OUR MONTHLY STATEMENT CYCLES. THERE WILL BE A FEW MONTHLY STATEMENTS THAT HAVE TWO MEDICATION CYCLES BILLED ON THEM. ****

FEE SCHEDULE

If medications are purchased at a pharmacy other than Granite Pharmacy, there is a $40.00 repackaging fee.

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of benefits for products and services rendered by us directly to Granite Pharmacy. I further expressly agree and acknowledge that my signature on this document authorizes Granite Pharmacy to submit claims for products and services rendered after this date without obtaining my signature on each claim. *I am responsible for all copays, deductibles and any balance that my insurance does not cover.* I am responsible for collection costs, attorney fees and court costs as permitted by law if such are incurred by Granite Pharmacy.

I have read or have had read to me the information above. My signature below documents my agreement with the terms of this agreement.

PATIENT NAME (printed) _____

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____