Ascension Rx

Ascension Rx Specialty Pharmacy

PATIENT DEMOGRAPHIC FORM

(PLEASE PRINT LEGIBLY)

URAC ACCREDITED
Specialty Pharmacy
Expires 03/01/2025

Patient Name_____ Date of Birth_____ Sex **M F**

Home Address_____ City_____ State_____ Zip _____

Primary Phone _____ Secondary Phone_____

Email Address_____

***ALLERGIES_____

Emergency Contact #1

Name_____ Relationship_____

Phone #_____ Alternative Phone #_____

Emergency Contact #2

Name_____ Relationship_____

Phone #_____ Alternative Phone #_____

Contacting You: We usually contact you by phone about your prescriptions and refills:
Is it okay to leave a message rather than just our phone number? (Circle one) **YES NO**

PLEASE UPDATE THE PHARMACY AS SOON AS POSSIBLE IF YOU MAKE ANY CHANGES TO YOUR ADDRESS, CONTACT INFORMATION OR INSURANCE

ACKNOWLEDGEMENT OF WELCOME PACKET INFORMATION

I confirm that I have read the Ascension Rx Specialty Pharmacy Welcome packet and understand what it says and will comply with these *INFORMATIONAL FORMS:*

Contact Information
Financial Responsibility
Notice of Privacy Practices
SCAM Warning
Hours of Operation
Patient Bill of Rights and Responsibilities
Medication Disposal Guide

Patient Signature_____**Date**_____

Ascension Rx

RELEASE OF INFORMATION

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I,_____ hereby authorize to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavior medication services, if any including communications made by me to a social worker or psychologist, and an information regarding communicable disease and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below:

1. Name of person(s) or organizations, to whom information is to be released to:

   Name _____ Relationship _____

   Contact Phone #_____

I understand that my protected health information disclose under this Authorization may be subject to re-disclosure by the individual or organization named above and its privacy will no longer be protected by law.

2. Specific type of information to be disclosed:

   The authorized person *must* initial next to the type of information to be disclosed.

   ____ Prescriptions
   ____ Delivery Arrangements for Prescriptions
   ____ Health Status and issues related to treatment with your medications
   ____ Payment and financial arrangements for your medications
   ____ Insurance and financial assistance related to your medications

3. This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end with the purpose for the release has been achieved. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law.

4. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon completion of therapy after the signature date below, whichever is later.

Signature of Patient _____ **Date** _____

Name (Please Print) _____