FAMILY PHARMACY &
HEALTHY LIVING CENTER
5403 Pinnacle Point Drive
Rogers, AR 72758

APPLICATION FOR CREDIT

RESIDENT'S NAME - ____
FIRST MIDDLE LAST

FACILITY NAME - ____

ADDRESS - ______________________________ APT # __________
STREET

____
CITY STATE ZIP

SSN - _____ - ____ - ______ DATE OF BIRTH - ____/____/________

STATEMENT TO BE SENT TO - ____________________________

ADDRESS - ____
STREET

____
CITY STATE ZIP

PRIMARY CONTACT PHONE - _____ - _____ - _______

PRIMARY EMAIL ADDRESS - ____________________________

YOU MAY FAX THIS COMPLETED APPLICATION TO: 479 – 254 - 9809

Please attach an executed Power of Attorney document!

IMPORTANT

In order to provide timely service to your family member we MUST be able to rely on the prescription authorizations we are given. Therefore, YOU ARE FINACIALLY RESPONSIBLE FOR ANY AND ALL MEDICATIONS ORDERED BY A PHYSICIAN, THE STAFF OF THE FACILITY OR YOUR FAMILY MEMBER FOR THE BENEFIT OF YOUR FAMILY MEMBER! Your signature below indicates that you have read, understood and agree to the importance of this responsibility on the part of the pharmacy.

SIGNATURE ______________________________ DATE - ____/____/____

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NAME OF PRIMARY CARE PHYSICIAN (PCP):

____

INSURANCE CARD INFORMATION FOR MEDICATION PROCESSING

BIN # - ______________________

ID # - ______________________

Rx GROUP # - ________________

Rx PCN # - ___________________

Arkansas Medicaid # - __________ (if applicable)

Billing Options: You will be provided an itemized statement every month for the pharmaceutical services provided. Payment is due upon receipt and can be made on the account in one of two ways:

1. We recommend completing the bank draft authorization on the following page. Payment will be drafted from your selected checking account after statements are processed and your copy will notate DO NOT PAY.
2. You may provide a credit card to be maintained on file. Your credit card will be charged after statements are processed and you will receive a copy of the credit card receipt along with the statement for your records.

CREDIT CARD INFORMATION (if you select payment option #2)

Circle Card Type: VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date on Card: ____ / _____ **(MM/YYYY)**

Security Code: _____ **(see back of card, last 3 digits)**

House Numbers: _____ **(where credit card billing statement is mailed to)**

Zip Code: __________ **(zip code of billing statement)**

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AUTHORIZATION FOR DIRECT PAYMENTS (ACH DEBITS)

I (we) hereby authorize Debbie's Family Pharmacy & Healthy Living Center, hereinafter call COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) Checking Account indicated below at the depository financial institution named below hereafter called DEPOSITORY, to reimburse COMPANY for medications and related services provided to us, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY NAME ______________________________

BRANCH LOCATION ______________________________

ADDRESS ______________________________________

CITY ____________________ STATE ____ ZIP ________

ROUTING NUMBER ______________________________

ACCOUNT NUMBER ______________________________

You must attach a voided check for number verification!

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

PRINTED NAME _______________________ SSN ____-___-______

SIGNATURE __________________________ DATE ___/___/______

ADDRESS ____

CITY ____________________ STATE ____ ZIP ______________

BEST CONTACT TELEPHONE (____) _____ - _________