



Pharmacy Services and Health Information Agreement

Our dedicated staff works diligently to provide services in a timely manner in spite of the often complex issues related to insurance coverage. Even with our best efforts there may be times when your insurance will not cover all charges, resulting in out of pocket costs to you.

In order to protect you from incurring charges without your approval:

Please select either Option 1 or Option 2 below.

Option 1

I DO NOT authorize Korman Healthcare to dispense over the counter (OTC) and prescription medications and products not reimbursed by my insurance. I am responsible to coordinate these needs directly with the community.

Initial here: _____

Option 2

I DO authorize Korman Healthcare to dispense over the counter (OTC) and prescription medications and products not reimbursed by my insurance. I agree to reimburse Korman Healthcare's charges for these items in accordance with the terms of the Korman Healthcare 3rd Party Billing Authorization/Insurance Agreement.

I acknowledge that per Arizona law, medications (including OTCs) are NOT returnable.

Initial here: _____

Durable Power of Attorney must accompany this form if not signed by Cardholder

I authorize Korman Healthcare to process my credit card for all Pharmacy purchases, and mail receipts to:

Responsible Party Name:		Responsible Party Address:	
Card Type (Check One): <input type="radio"/> VISA <input type="radio"/> MASTERCARD <input type="radio"/> DISCOVER		Responsible Party City, State and Zip	
Responsible Party Signature:	Date	CARD #:	EXP. DATE:
Responsible Party Phone Number		Permission to send text messages to responsible party (phone carrier charges may apply). (Check Yes or No)	<input type="radio"/> Y <input type="radio"/> N

CHILD SATETY WAIVER: YOU AGREE TO WAIVE THE CHILD-RESISTANT SAFETY CAP REQUIREMENT FOR ALL NEW PRESCDRPTIONS AND REFILLS. BUBBLE PACK/BINGO CARDS/PRATA ARE NOT CHILD SAFE AND SHOULD BE KEPT OUT THE REACH OF CHILDREN AT ALL TIMES.

Initial: _____

Patient Health Information

Patient/Resident further authorizes the Pharmacy to have access to and disclose any medical and/or insurance information in its possession: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payor who may be responsible for payment of Pharmacy services.

I (Patient/Resident) DO NOT select Korman Healthcare as my preferred pharmacy and accept no responsibility for charges which I have not explicitly approved in advance.

Initial: _____

Agreement not valid unless signed

Patient/Resident/Power of Attorney Signature:	Date	Patient/Resident/Power of Attorney (Print):
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(Revised MARCH 2020, please discontinue use of all previous versions).