GORDON FAMILY PHARMACY
518 S Broad St
Brevard, NC 28712
PHONE: (828)877-6111
FAX: (828)877-6487

CAMP ILLAHEE EST. 1921

CAMP ILLAHEE
500 Illahee RD
Brevard, NC 28712
PHONE: (828)883-2181
FAX: (828)883-8738

PHARMACY FORM

WE WILL DO OUR BEST TO PROCESS PRESCRIPTIONS THROUGH YOUR INSURANCE BUT PLEASE UNDERSTAND THAT SOME INSURANCE COMPANIES DO NOT CONTRACT WITH ALL PHARMACIES. YOU ARE FULLY LIABLE FOR ANY BALANCE NOT PAID BY YOUR INSURANCE. THE $2.50 FEE GORDON CHARGES FOR BLISTER PACKAGING IS NOT COVERED BY INSURANCE.

ALL FIELDS ARE REQUIRED: **SESSION START DATE:** _____

Camper's First and Last Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Drug Allergies: _____

Insurance Company: _____ Name of Cardholder: _____

RxBin # _____ RxPCN#_____ Cardholder ID# _____ RxGroup# _____

Name of Current Pharmacy and Phone # _____

Name of Medications that need to be transferred: _____

_____

Over the counter medications needed: _____

PLEASE ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARD TO THIS FORM

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE COST OF ANY MEDICATION NOT COVERED BY MY INSURANCE COMPANY, FOR ANY MEDICATION THE PHARMACY CANNOT GET REIMBURSED FOR, AS WELL AS ANY CO-PAYMENTS, DEDUCTIBLES, AND CHARGES FOR OVER THE COUNTER MEDICATION WHICH I AUTHORIZE TO BE CHARGED DIRECTLY TO MY CREDIT CARD BY GORDON FAMILY PHARAMCY. IF I AM SUBMITTING INSURANCE INFORMATION, I AGREE TO AUTHORIZE GORDON FAMILY PHARMACY TO CONTACT MY INSURANCE COMPANY FOR INSURANCE VERIFICATION, BLILLING, AND COLLECTIONS FOR MY CHILD'S MEDICATIONS. OUR LICENSED PHARMACY IS HIPPA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE SOLELY MAINTAINED FOR THE PURPOSE OF FILLING PERSCRIPTIONS AND PROCESSING INSURANCE CLAIMS.

Parent/Guardian printed name: _____

Parent/Guardian signature: _____ Date: _____

OVER FOR PAYMENT AGREEMENT

GORDON FAMILY PHARMACY
518 S Broad St
Brevard, NC 28712
PHONE: (828)877-6111
FAX: (828)877-6487

PAYMENT AGREEMENT

WE REQUIRE THAT YOU SUBMIT A CREDIT CARD NUMBER TO COVER ALL MEDICATIONS AND THE BLISTER PACKAGING FEE.
OUR PHARMACY DOES NOT ACCEPT AMERICAN EXPRESS

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV# _____

Credit Card Type: _____ Zip Code: _____

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE COST OF ANY MEDICATION NOT COVERED BY MY INSURANCE COMPANY, FOR ANY MEDICATION THE PHARMACY CANNOT GET REIMBURSED FOR, AS WELL AS ANY CO-PAYMENTS, DEDUCTIBLES, ADN CHARGES FOR OVER-THE-COUNTER MEDICATION AUTHORIZED TO BE CHARGED. OUR LICENSED PHARMACY IS HIPPA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE SOLELY MAINTAINED FOR THE PURPOSE OF FILLING PERSCRIPTIONS AND PROCESSING INSURANCE CLAIMS AND PAYMENTS.

Parent/Guardian printed name: _____

Parent/Guardian signature: _____ Date: _____