GORDON'S FAMILY PHARMACY

518 SOUTH BROAD STREET
BREVARD, NC 28712
PHONE: (828) 877-6111
FAX: (828) 877-6487
gordonfamilypharmacy@gmail.com

WELCOME TO GORDON'S FAMILY PHARMACY. WE LOOK FORWARD TO TAKING CARE OF YOUR CHILD'S PRESCRIPTIONS.

WE WILL DO OUR BEST TO PROCESS PRESCRIPTIONS THROUGH YOUR INSURANCE BUT PLEASE BE AWARE OF THE FOLLOWING:

*SOME INSURANCE COMPANIES DO NOT CONTRACT WITH ALL PHARMACIES.
*YOU ARE LIABLE FOR ANY BLANCE NOT PAID BY YOUR INSURANCE.
*THERE IS A $7.00 FEE WE CHARGE FOR EACH BLISTER PACK. THIS FEE COVERS BLISTER PACK SUPPLIES AND IS NOT COVERED BY INSURANCE.

PLEASE FILL OUT ATTACHED FORM AND SEND IT BACK TO GORDON'S (NOT YOUR CHILD'S CAMP) AS SOON AS POSSIBLE. COMPLETED FORMS CAN BE RETURNED VIA MAIL, EMAIL, OR FAX.

WE NEED ALL INFORMATION TO BE SUPPLIED **1 MONTH BEFORE** YOUR CHILD'S CAMP SESSION STARTS OR THERE WILL BE A $20 LATE FEE.

PLEASE DIRECT ANY QUESTIONS TO AMBER AT (828) 877-6111 or gordonfamilypharmacy@gmail.com

PLEASE CONFIRM THERE ARE REFILLS ON ALL PRESCRIPTIONS BEING TRANSFERRED. IF THERE ARE NO REFILLS, YOU WILL NEED TO CALL YOUR PHYSICIAN'S OFFICE AND HAVE A NEW SCRIPT SENT DIRECTLY TO GORDON'S.

KEEP IN MIND THAT INSURANCE COMPANIES MAY NOT PAY FOR EARLY REFILLS. IN THIS CASE, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE BUT WILL BE HAPPY TO PUT IT ON OUR DISCOUNTED GORDON FAMILY PLAN.

SOME OVER THE COUNTER MEDICATIONS MAY NEED TO BE SPECIAL ORDERED FOR YOUR CHILD AND MAY NEED UP TO A WEEK TO SHIP. WE WILL NEED ALL FORMS A MONTH IN ADVANCE TO ACCOMODATE OVER THE COUNTER MEDICATIONS.

OCCASIONALLY SOME MEDICATIONS MAY NOT BE AVAILABLE DUE TO NATIONWIDE SHORTAGES. IN THIS INSTANCE, WE MAY ASK YOU TO MAIL YOUR CHILD'S MEDICATIONS.

PLEASE ADD GORDON'S PHONE NUMBER TO YOUR CONTACT LIST IN CASE WE NEED TO CONTACT YOU REGARDING YOUR CHILD'S MEDICATIONS.

PLEASE SUPPLY AN ACTIVE CREDIT CARD NUMBER SO WE CAN HAVE BLISTER PACKS DELIVERED TO YOUR CHILD'S CAMP THE FRIDAY BEFORE THE SESSION STARTS.

AGAIN, PLEASE SEND ALL FORMS ONE MONTH BEFORE THE SESSION STARTS TO MAKE SURE WE HAVE TIME TO GET THE SE BLISTER PACKS ASSEMBLED AND TO AVOID A $20 LATE FEE.

THANK YOU!

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 LIABLE FOR ANY BALANCE NOT PAID BY YOUR INSURANCE. THE $7.00 FEE FOR BLISTER PACKAGING COVERS BLISTER PACK SUPPLIES AND IS NOT COVERED BY INSURANCE.

ALL FIELDS ARE REQUIRED:

CAMP ATTENDING: _____ SESSION DATE: _____

Camper's First and Last Name: _____Gender: _____Date of Birth: _____

Gaurdian Name and Phone Number: _____

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, BILLING, 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

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PAYMENT AGREEMENT

WE REQUIRE THAT YOU SUBMIT AN ACTIVE CREDIT CARD TO COVER ALL MEDICATIONS AND THE $7.00 BUBBLE PACK FEE. OUR PHARMACY DOES NOT ACCEPT AMERICAN EXPRESS.

NAME ON CARD: _____

CREDIT CARD #: _____

EXPIRATION DATE: _____ CVV: _____

CREDIT CARD TYPE: _____ ZIP CODE: _____

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PARENT/GUARDIAN PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

PLEASE FEEL FREE TO CONTACT GORDON FAMILY PHARMACY WITH ANY QUESTIONS OR CONCERNS YOU MIGHT HAVE.

THANK YOU!