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

2024 PHARMACY FORM

WELCOME TO GORDON 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 BALANCE NOT PAID BY YOUR INSURANCE.

THERE IS A $9.00 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 TO 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 $25.00 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 ACCOMMODATE 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 DIRECTLY TO GORDON'S.

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 SESSION STARTS.

AGAIN, PLEASE SEND ALL FORMS ONE MONTH BEFORE SESSION STARTS TO MAKE SURE WE HAVE TIME TO GET THESE BLISTER PACKS ASSEMBLED AND TO AVOID A $20.00 LATE FEE.

THANK YOU FROM GORDON FAMILY PHARMACY.

PLEASE ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARD WITH 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 PHARMACY. IF I AM SUBMITTING INSURANCE INFORMATION, I AGREE TO AUTHORIZE GORDON FAMILY PHARMACY TO CONTACT MY INSURANCE COMPANY FOR INSURANCE VERIFICATION, BILLING, AND COLLECTION'S 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 PRESCRIPTIONS AND PROCESSING INSURANCE CLAIMS.

Parent/Guardian Printed Name:_____

Signature:_____ **Date:**_____

ALL FIELDS ARE REQUIRED:

CAMP ATTENDING:_____

SESSION DATE:_____

Student's First and Last Name: _____ **Gender:**_____ **Date of Birth:**_____

Guadian Name and Phone Number_____

Street Address:_____

City/ State/ Zip: _____

Drug Allergies: _____ **Insurance Company:** _____

Name of Cardholder: _____ **Rx Bin #** _____ **Rx PCN #** _____

Cardholder ID #_____ **Rx Group #**_____

Name of Current Pharmacy and Phone Number:_____

Name of Medications that need to be transferred_____

_____

Over the Counter Medications Needed _____

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PAYMENT AGREEMENT

WE REQUIRE THAT YOU SUBMIT AN ACTIVE CREDIT CARD TO COVER ALL MEDICATIONS AND THE $9.00 BUBBLE PACK FEE.

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, AND CHARGES FOR OVER THE COUNTER MEDICATION AUTHORIZED TO BE CHARGED. OUR LICENSED PHARMACY IS HIPAA COMPLIANT AND ALL PERSONAL INFORMATION RECEIVED WILL BE SOLELY MAINTAINED FOR THE PURPOSE OF FILING PRESCRIPTIONS AND PROCESSING INSURANCE CLAIMS AND PAYMENTS.

PARENT/GUARDIAN PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

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

THANK YOU!