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Mount Vernon, OH 43050
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Kenyon College Health Center Patient Information and Delivery Agreement

Please send insurance info with this form

Name: _____ D.O.B.: _____ M F

Kenyon PO Box: _____ Student Mobile Number : _____

Student E-Mail: _____ Medication Allergies: _____

Do you want to be enrolled in our auto-refill program (**only for non-controlled medications**)?

_____YES _____NO **Academic Year -** Fr So Jr Sr

Home Address and Zip Code: _____

Parent Phone Number: _____

Patient Contact Authorization Form

Respect for your privacy is a top priority at Conway's Eastside Pharmacy (CEP). Conway's Eastside Pharmacy practices in compliance with federal regulations that are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI"). We have patients request that we leave detailed voice messages about their prescription or we have patients notify us that a friend or family member will be picking-up their prescription. While we try to accommodate our customers, we also must adhere to HIPAA regulations. The form below will allow us to leave voice messages at specific telephone numbers, authorize prescription pick-up contacts, and release information about you, the patient, to those authorized by you. (This required for those patients 18 and older).

Can Conway's Eastside Pharmacy leave voice messages at the numbers you provide below? (Please circle your choices.)

Student Mobile Phone: _____ Yes / No Detailed or Basic Message Authorized

Parent Phone: _____ Yes / No Detailed or Basic Message Authorized

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These individual(s) have been selected by the patient listed above as an authorized contact for the specified information.

1.) _____

Authorized Contact Full Name (Print) Telephone Relation

Information to Be Released to Contacts: Patients, 18 and older, are to select information and/or items that the above individual(s) listed can receive and are authorized to know. **Please INITIAL by all items or information that can be released to the above individual(s).**

_____ Medical Information (Any information regarding your health diagnosis and treatment plans, etc.)
_____ Financial Information (Any information regarding your insurance, payment plans, credit & balances, etc.)
_____ Prescription Pick Up (All individuals who are picking up prescriptions must show a form of identification.)
_____ Documentation Pick Up (All individuals who are picking up any documentation must show a form of identification.)
_____ Authorization to request fill/refill of prescriptions on students behalf.

Patient Signature: _____ Date: _____

PLEASE NO LYING OR FAKE SIGNATURE FOR THE PATIENT ON THE ABOVE LISTED SIGNATURE!

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Authorizing Patient Information NOT to be Released – (for patients 18 years and older)

By signing this section below, you are choosing **NOT to release ANY of the above information to ANY individual(s) other than yourself**. This means that spouses, children, family members, etc. cannot pick-up prescription(s) or access any information regarding your prescription(s) filled at EFP.

Patient Signature: _____ Date: _____

☐ I agree to have Conway's Eastside Pharmacy (CEP) fill and arrange for delivery of my prescriptions to my Kenyon College mailing address. The same day delivery cut off time is 2pm.

☐ I understand and agree to cover all prescription cost/copays and delivery charges ($5.00) with the form of payment provided below. I understand CEP will charge my credit card for the above referenced charges. In the event my form of payment does not allow approval of charge, CEP has the right to cancel/hold delivery of my medication and attempt to notify me of such cancellation. If no approval is made by 3pm Monday-Friday my medication will not be delivered that same day.

☐ I understand that CEP WILL NOT exchange medication or return any monies paid once on any order that was shipped. This is pursuant to State pharmacy law OAC 4729-9-04. I understand I must check my designated PO box before end of academic year and academic breaks and that CEP cannot return any medications if not picked up or return any payments.

CREDIT CARD AUTHORIZATION

Name on Card: _____ Billing Address: _____

__ Visa __MC __AMEX __Discover

Card Number_____ Expiration_____ Security Code____

_____ I authorize Conway's Eastside Pharmacy to charge my credit card for prescription and delivery charges. I understand and agree that I responsible for all the charges for prescriptions and delivery services rendered from CEP.

X _____

Cardholder/Patient Signature & Date

CONFIDENTIALITY AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices (NOPP) of Conway's Eastside Pharmacy, posted in the pharmacy or have been given my own copy. I acknowledge that I agree with the patient authorization information provided above.

I understand that Conway's Eastside Pharmacy, through its HIPAA policies is obligated to protect my confidental personal health information. I have the right to request to see their HIPAA policies at any time. Conway's Eastside Pharmacy reserves the right to change the terms of its Privacy Notice. If such changes are made, I understand that the Privacy Notice will be posted on the CEP website and I can request a copy at any time.

I understand that I am responsible to provide current and accurate insurance information to Conway's Eastside Pharmacy and a copy of their current insurance card. I also understand that a delay in getting current and accurate insurance information to the pharmacy will result in a delay in getting my prescriptions. I understand that I may also get an option to pay out-of-pocket for prescription(s) if I cannot obtain current and accurate insurance informationin a timely manner.

I verify by my signature below that I give permission for prescription(s), over-the-counter item(s) and delivery services; I have been informed of my privacy rights; I am responsible for charges on my credit card and authorize of my health informtion to process any insurance claims.

_____ _____

Signature of patient **Date**

_____ _____

Signature of parent (if patient is under 18) **Date**