PREMIERMED FAMILY AND SPORTS MEDICINE
Patient Registration Packet 2022
Please e-mail this form to info@premierfsm.com

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Last Name: _____
Date of Birth: ____/____/_____ Social Security #: _____ - _____ - _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Secondary Phone: _____
Email Address: _____

Marital Status: ▢Single ▢Married ▢Divorced ▢Widowed ▢Separated

Sex: ▢Male ▢Female Gender: _____ Pronouns: _____

Race: ▢White ▢Black or African American ▢American Indian or Alaska Native ▢Asian

▢Native Hawaiian or Pacific Islander ▢Decline

Ethnicity: ▢Hispanic/Latino ▢Not Hispanic/Latino ▢Decline

EMERGENCY CONTACT & CONSENT FOR DISCLOSURE

I agree that PremierMED Family & Sport Medicine may disclose my medical information to me and the following individual(s) in the event I am not physically present, including disclosures by telephone, voice mail, facsimile, e-mail, or regular mail. I agree to let certain individual(s) participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for PremierMED Family & Sport Medicine and/or staff to disclose my personal medical information to the following individuals.

Contact First/Last Name: _____
Relation: _____ Contact Number: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____

INSURANCE

Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder: _____ Relation to Patient: _____
Date of Birth: ____/____/_____ Policy Holder SSN: _____ - _____ - _____

Secondary Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder: _____ Relation to Patient: _____
Date of Birth: ____/____/_____ Policy Holder SSN: _____ - _____ - _____

OFFICE USE ONLY

SCANNED PICTURE ID: _____ SCANNED INSURANCE CARD: _____
ALL FORMS REVIEWED BY: _____

Parental Consent for Medical Treatment of a Minor

To avoid a possible delay in providing medical treatment in the event your child becomes ill or injured in your absence, PremierMED offers this form for medical consent. It offers assurance that your minor child will receive prompt, personalized attention if you or a legal guardian are not immediately available. By signing this you agree to treatment, testing, and the administration of medication, including vaccines, deemed medically necessary by the rendering physician.

Patient First/Last Name: _____ Date of Birth: ____/____/_____

CURRENT MEDICATIONS (Leave blank if not currently taking medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES/MEDICATION SIDE EFFECTS (Please list the agent/medication and reaction)

_____
_____
_____

Parent / guardian 1:

Name: _____ Relation: _____
Phone: _____ Secondary Phone: _____
Home Address: _____

Parent / guardian 2:

Name: _____ Relation: _____
Phone: _____ Secondary Phone: _____
Home Address: _____

Other caregiver:

Name: _____ Relation: _____
Phone: _____ Date of Birth: ____/____/_____

I, the parent/ guardian, authorize the above adult caregiver to consent to any necessary examination, medical diagnosis, etc. to be rendered to the above-named minor child under the general supervision and on the advice of a PremierMED licensed physician. Additionally, I agree to pay for all services provided to my child in my absence.

Signature of Parent / Guardian: _____ Date: _____

You may amend this consent in writing at any time. Otherwise, this consent form does not expire.

Marketplace/ACACare Insurance Financial Policy

The Affordable Care Act (ACA) created the Advance Premium Tax Credit (APTC) to assist patients in paying their health insurance premiums. This tax credit does not subsidize the entire premium, and as such, you are responsible for paying the remainder of your health insurance premium.

If you purchased your health insurance through the ACA website (www.healthcare.gov), you are required to make your monthly premium payments to avoid a 90-day grace period, which puts you at risk of losing your coverage if payment is not made in full at the end of the grace period.

According to federal regulation §156.270, your insurance carrier is required to notify us if you have defaulted on your premium payments. If we receive such notification from your insurance carrier, we will send you a statement for the balance due on your account for services rendered at PremierMED Family and Sports Medicine. Your account will be placed in a self-pay status until your premium's payments are made in full (we will call your insurance carrier for confirmation of payment). If your policy is canceled due to non-payment of premiums, your account with PremierMED Family and Sports Medicine will remain in a self-pay status.

If your balance with PremierMED Family and Sports is not paid in full after 90 days, your account will be forwarded to a collection agency to collect on your account.

By signing this policy below, the patient/parent confirms that:

I understand and acknowledge that I am personally responsible to pay PremierMED Family and Sports Medicine in full for services that my health insurance payer will not cover due to non-payment of my health insurance premiums. I further understand and acknowledge that my account will be placed in a self-pay status, and I am at risk for my account being forwarded to a collection agency if I do not pay my balance in full.

I confirm that I have **not** purchased insurance through ACA (www.healthcare.gov). I have insurance through my employer or another private/commercial or Medicare plan, or I am a self-pay patient.

_____

Patient Name/Signature Date

I confirm that I **have** purchased insurance through ACA at www.healthcare.gov; I will comply with this policy regarding my account.

_____

Patient Name/Signature Date

Patient Financial Policy

Our goal at PremierMED Family and Sports Medicine is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our financial policy allows us to maintain a good flow of communication and run an efficient medical practice.

We verify insurance eligibility for every patient prior to their scheduled appointments and for all walk-in patients. To maintain a strong financial standing while providing excellent medical care, we have implemented a financial policy of collecting all copays, deductibles, and co-insurances **the day** of your visit. If we find that you have overpaid, we will issue a refund once the Billing Department reviews your Explanation of Benefits (EOB). If you still have patient responsibility left over, we will send you a statement with a balance due.

FOR PATIENTS WITH INSURANCE:

It is your responsibility to know and understand your insurance policy coverage to include visits, annual wellness visits, labs and procedures.

If you are responsible for a deductible or co-insurance, we will collect a fee up front for your visit, if you have further responsibility, you will be billed for these services:

- **INSURANCE** – We will file claims on all visits and procedures. When we file a claim on your behalf, it is with understanding that benefits will be assigned to PremierMED Family and Sports Medicine, LLC dba PremierMED Family and Sports Medicine. You are responsible for all co-payments, deductibles, co-insurance, and non-covered services. ***THE ULTIMATE RESPONSIBILITY FOR UNDERSTANDING YOUR INSURANCE BENEFITS REGARDING PAYMENTS, PREVENTATIVE SERVICES, COVERAGE FOR PHYSICIAN AND LAB SERVICES, PATHOLOGY, RADIOLOGY, AND VACCINATION COVERAGE RESTS WITH YOU.** ***

- **AFTER HOURS** - If you are seen **after 5pm during the week, or on Saturday, it is considered after-hours**. The after-hours reimbursement billing code (99050) will be submitted for such visits. Your insurance plan may or may not cover this, and therefore, you may or may not incur patient responsibility. Once we receive the explanation of benefits (EOB) from your insurance company, our billing department will review your account to determine your responsibility and send you a statement for remittance of payment if necessary.

- **PREVENTATIVE PHYSICALS WITH LAB REVIEW OR OTHER ADDRESSED ISSUES/CONCERNS** – While your physical exam (preventative/wellness exam) may be covered by your insurance plan, the lab review component of the visit, or other acute complaints or medication refills addressed during the exam are not considered preventative and will be billed as such. This portion of your visit may or may not be covered by your insurance, and you will be responsible for any remaining balance applied by your insurance company.

- **PAYMENTS:**

o CASH PAYMENTS – Payments of **$25 or less** are cash only. Please note the following:
o We will not accept credit or debit card payments for **$1.00, $2.00, or $5.00** payments.

o ACCEPTED TYPES OF PAYMENT: Cash, Visa, MasterCard, and Discover. NO PERSONAL or BUSINESS CHECKS will be accepted.

• **LAB FEES (except Medicare)** – If your provider orders labs, you are welcome to visit a LabCorp or Quest lab facility. We do offer you the convenience of having your labs drawn at PMFSM; a lab draw/convenience fee of $25 will be collected for **physical exams, your initial visit, or any follow-up visit. This includes labs drawn during a walk-in visit**. Your lab specimen(s) will be sent to LabCorp or Quest based on your insurance.

• **NEW PATIENTS** – New patients are responsible for co-payments/co-insurances/self-pay fees up front. Payment arrangements for first visits are not authorized.

• **ADMINISTRATIVE FEES/ FORMS**

PremierMED Family and Sports Medicine prides itself on providing excellent medical care and customer service to you and your family. We encourage you to schedule an appointment specifically for the completion of the document. This ensures that the document is completed accurately. We require that you must be an established patient with a physical exam within a rolling calendar year. We can also provide administrative services to patients upon request. If you require a specific form, paperwork, or letter for your employer or other reasons, we will charge an administrative fee based on the request. Fees must be paid in full before the letter or administrative service is completed. You must allow 7 days for any form(s) to be completed. You will be notified when your letter or paperwork is complete and ready for pick-up at the front desk.

1. Letter typed and printed on company letterhead, and signed by the physician or other provider (example: special travel arrangements, requirements for service, work accommodations, etc.): **$25**
2. Forms or paperwork for work accommodations (not FMLA), handicap parking placards: **$25**
3. Family Medical Leave Act (FMLA): this requires a face-to-face encounter/appointment with a physician. You will be charged your normal office visit fee, and an **additional $50** to complete the FMLA packet.
4. Disability (Short or Long Term): you must be an established patient for at least one year with a physical before disability forms are completed: **$50**
5. Requests for admission into a nursing home or assisted living facility: you must be an established patient for at least one year with a physical: **$25**
6. 3rd party request for paper records **$1 per page up to $25 plus the cost of mailing**.

Patient Status and Appointment Policy

• **PATIENT EXPECTATIONS**: At PremierMED Family and Sports Medicine, we do regular check-ups, counseling, and screenings to prevent illness and disease progression. Annual Wellness Exams and Well Woman Exams are considered wellness visits. Complete physical exams are preventative visits that screen patients for common health conditions and include a head-to-toe assessment. A baseline reading of your lab results, blood pressure, temperature, pulse, respirations, weight, height, and other vital functions depending on your age and level of activity. We request all patients 21 and over to have labs drawn 7-10 days prior to their annual physical exam. **Annual Wellness Exams

cannot be scheduled during the same visit as new patient consultation, acute visit, or other requested appointments** **YOU WILL BE EXPECTED TO HAVE AN ANNUAL PHYSICAL AND AGE-RELATED SCREENING EXAMS TO RETAIN YOUR PATIENT STATUS. If you are unable or unwilling to comply with these expectations, we encourage you to seek care at another practice.**

• **LATE APPOINTMENT & CANCELLATION POLICY/FEES** – In the event that you need to cancel or reschedule your appointment, a 24-hour notice during business hours is required. Appointments cancelled within the same day, marked as a no show or if you arrive late (or call to notify of late arrival) ***more than 10 minutes***, your appointment will be cancelled/rescheduled and subject to cancellation fee of $50. If you arrive late, but *before* the 10 minutes, you may still be seen, but other patients showing on time for their appointment will be seen first.

• **APPOINTMENTS** – Office visits are by appointments only. However, if you develop sudden illness and require an appointment on the same day, we will do our best to addecimate you. Please understand that you may be seen by a different provider for that particular visit in order for us to care for you in a timely manner. Informing our reception staff beforehand about the nature of your appointment will ensure your appointment is equipped with enough time for your visit. We provide our patients with three forms of appointment reminders: email and text messages, and phone call. **It is your responsibility to confirm your appointment.**

• **HOSPITAL ADMISSIONS** – If you are admitted to the emergency department and/or the hospital, please make sure to inform the hospital admission staff of your primary care physician's name, follow ups with your primary care physician is required 7-14 days after your hospitalization to help avoid readmissions and/or complications.

• **AFTER HOURS ANSWERING SERVICE** If you contact our office after business hours, an after-hours answering service will be available. This service is only to assist you with acute (non-life threatening) urgent situations. **Please note this is not for emergencies, call 911**. Appointment cancellations, prescription refill requests, referral requests, and knowledge of test results are services NOT offered with the after-hours answering service.

• **NON-COVERED SERVICES** – Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and medically necessary". If Medicare or another insurance company determines that your visit with our physician or nurse practitioner is not "reasonable and medically necessary", they will deny payment for that service. **You will be responsible for anything not covered by Medicare or your insurance company.** All labs are submitted based on **appropriate codes** to a lab based on one's medical condition.

• **PAST DUE ACCOUNTS** – Unpaid balances must be resolved **prior** to being seen in the office. If necessary, you can visit portal.athenahealth.com to pay your balance. If your account is 90 days past due, your account is subject to collections from a third-party collection agency.

• **CARD ON FILE** - PremierMED Family and Sports Medicine will require you to have a card on file in order to schedule an appointment. This will be used to collect outstanding balances. You may also use your card on file to pay time-of-service payments. Payments will be processed up to $200.

Prior Authorization, Referrals, Prescription Refill, and Controlled Substances Policy

Our goal at PremierMED Family and Sports Medicine is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our Prescription Refill and Controlled Substances Policy allows us to maintain a good flow of communication and run an efficient medical practice. Please review the policy below:

MEDICATION FOR CHRONIC CONDITIONS

1. All new patients must establish with a PremierMED Family and Sports Medicine provider prior to having a prescription refilled.

2. Additional lab tests may be required to determine the exact dosages of prescribed medications; your insurance may or may not cover these tests. It is your responsibility to check with your insurance company to determine what they will cover.

3. Please contact your local or mail order pharmacy to request a refill 1-2 weeks prior to your refill date. Your pharmacy will then contact us by fax, please allow up to 3 business days for a response. DEA law states that all controlled substance medications require a 3 month follow up in office, we CANNOT submit a temporary refill.

4. Depending on the type of medication you are on; you must be seen by a PremierMED Family and Sports Medicine provider every three to six months (or more frequently if necessary) to have your prescription refilled. This will be considered a regular office visit and billed accordingly. You will also be required to have bloodwork at least every six months for medications for chronic conditions.

CONTROLLED SUBSTANCE AGREEMENT

1. Controlled substances (pain, sleep, muscle relaxants, stimulants, testosterone/hormone replacement) are tracked by the State of Florida Prescription Drug Monitoring Program (PDMP). Pharmacies and physicians can track your usage of controlled substances through obtaining an online report, which annotates physicians who have prescribed, and pharmacies who have dispensed these medications.
2. If the physicians at PMFSM are dispensing a controlled substance (non-narcotic pain medication, sleep medication, muscle relaxant, ADHD medications, testosterone, or hormone replacement), **you are required to have a face-to-face encounter every 3 months for prescription refills.**

3. New patients who request a controlled substance for acute pain may receive one prescription of pain medication or controlled substance (at the discretion of the physician) after a PDMP report is obtained.
4. I will attend all office visits and will come immediately if asked.
5. I will not go to the ER or to other providers for these or similar medications. I am personally responsible for their medication(s). I will treat them as other valuables. Medicines will not be replaced if lost, stolen, or destroyed.
6. I will not give medication(s) to anyone else or take anyone else's medication(s).
7. I will not request early refills or take more than the prescribed amount.
8. For safety reasons, refill requests will only be honored at the time of my appointments, during office hours, currently 8AM-5PM Mon-Thu, 8AM-1PM Fri.
9. I will inform my doctor of any new medications or medical conditions.
10. I agree to allow PremierMED to perform any urine, blood, or breath tests needed to make sure I use my medications correctly.
11. It is my responsibility to comply with applicable laws while taking these medications.
12. My providers may discuss my medications with other appropriate individuals or entities to ensure safety.
13. I understand that there can be side effects from these medicines, including sedation, itching, nausea, vomiting, difficulty urinating, constipation, and other problems.
14. I understand that I may become addicted to these medications.
15. I understand that suddenly stopping these medications may be dangerous.
16. If I violate these conditions, my providers may not refill the medications and may require that I obtain help to decrease my use of these medications.
17. I know that violating these conditions may result in my dismissal from the practice with no more than 30 days' notice.
18. I further agree that my pain medication or other prescriptions may be stopped or decreased at any time, for any reason, by my providers
19. I understand that the above is not a complete list. I will be careful and will exercise caution and common sense. I will be completely honest, open, and accurate about my use of these and all other medications. I will ask questions if I do not understand something or if I feel that I may be having trouble with the medication.

PRIOR AUTHORIZATIONS FOR MEDICATIONS AND REFERRAL FOR SPECIALISTS

We will make every effort to ensure that you receive the safest, most effective, and reasonably priced prescription drugs that are best suited for your healthcare. We also abide by regulations set by insurance companies and government agencies. Many health insurance companies or plans are requiring Prior Authorization or approval for your medication.

All referrals and prior authorizations to specialists or imaging centers require 48-72 hours for processing. For authorization procedures and/or pharmacy approvals please contact your health insurance company for further information.

Acknowledgement of
PremierMED Family and Sports Medicine
Registration Packet 2022

_____

Patient Name Date of Birth

o I have read and agree to the “PATIENT FINANCIAL POLICIES”

_____

Patient or legal guardian signature Date

o I have read and agree to the “PATIENT STATUS AND APPOINTMENT POLICIES”

_____

Patient or legal guardian signature Date

o I have read and agree to the “PRIOR AUTHORIZATION, REFERRALS, PRESCRIPTION REFILL, AND CONTROLLED SUBSTANCES POLICY”

_____

Patient or legal guardian signature Date

*A copy of these policies will accompany your consent in your medical record and can be provided to you for your record as well.

HIPAA Authorization Form

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, health plan, my employer or a healthcare clearing house, and related to my past, present or future physical or mental health condition; the provision of the healthcare to me; or the past present or future payment for the provision of health care to me.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) I, the undersigned grant permission to PremierMed FSM to disclose protected health information (as defined in HIPAA) to the following persons:

Name: _____ Relation: _____ Date of Birth: ____/____/_____

Name: _____ Relation: _____ Date of Birth: ____/____/_____

Name: _____ Relation: _____ Date of Birth: ____/____/_____

Purpose of Authorization:

▢At my request ▢Family assisting with health care ▢Other: _____

Any limitations I impose on PremierMED FSM with respect to this authorization are declared below:

▢STD testing/ results ▢Lab Results ▢Imaging/Scans ▢Other:_____

This release will remain in effect for one year from the undersigned date. In addition I may revoke this release at any time by notifying PremierMED FSM of the revocation in writing.

Authorization of HIPAA Release

I understand that by granting this release, the person who obtains this information may disclose it to other individuals with my consent and in doing so the information would no longer be protected under HIPAA. I understand that authorizing the use and disclosure of my information is not a condition of enrollment in this health plan eligibility for benefits or payment of claims.

_____

Date Patient's Date of Birth Patient's Name

_____

Guardian's Printed Name Patient or Guardian's Signature

Consent for Protected Health Information via Secure Text Messaging

I state my preference to have my physician, nurse practitioner, physician's assistant and/or other staff at PremierMED Family and Sports Medicine communicate with me by standard SMS messaging. This can be regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that standard SMS messaging is not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

Please note, we have implemented safeguards to ensure protection of your health information with the use of a secure text messaging service that specifically integrates with our electronic medical record. However, under the 2013 HIPAA Omnibus Rule, we must inform you of the risks involved with transmission of unencrypted texts.

I consent to communicate via text message with PremierMED Family and Sports Medicine.

_____

Patient or legal guardian signature Date

Authorization for Release of Medical Information

_____

Patient Name Date of Birth

_____

Phone Email

PLEASE SIGN FOR FUTURE USE.
I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form may be revoked in writing and otherwise expires five years from the date listed below. **Note: If these records obtain any information from previous providers, or information about cancer diagnosis, drug/alcohol abuse, sexually transmitted diseases, HIV/ AIDS, and mental health you are hereby authorizing disclosure of this information.

_____

Patient or Parent/Guardian Signature Date

In office use only

_____
Name of Clinic/Physician Releasing Records

_____/_____
Phone Fax

RECORDS REQUESTED BY:

_____ Gary Visser, MD, FAAFP
_____ Adam Langley, MD, FAAFP
_____ Ferdinand Brits, MD
_____ Anri Brits, MD
_____ Ed Roberts, MD
_____ Heather Sheldon, ARNP
_____ Carolyn Knopfle, ARNP

Please include the following and fax to our office:

_____ STAT: PATIENT IN OFFICE
_____ ROUTINE: Send records ASAP
_____ Progress notes / HPI / H&P
_____ Pathology Reports
_____ Radiology Exams
_____ Immunization Records
_____ All Diagnostic Results

MEDICAL HISTORY (Leave blank if no past/current medical history)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

SURGICAL HISTORY (Leave blank if no surgical history)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you currently see any specialists? (Please list the name, specialty, and location.)

_____
_____
_____
_____

Do you need any referrals today? If so, please state the type of specialist and the reasoning for the referral. If you have the provider picked out please list that as well.

_____

SOCIAL HISTORY

Occupation: _____ Employer: _____

☐Retired ☐Homemaker ☐Student ☐Unemployed

Who lives with you?

☐Spouse/Partner ☐Children ☐Roommates ☐Parents ☐Other

Tobacco use (including cigars/vape/smokeless):

☐Current everyday ☐Current someday ☐Former smoker ☐Never used

Alcohol use (beer/wine/liquor):

☐1-3 ☐4-6 ☐7+ per ☐Day ☐Week ☐Month ☐Year ☐No alcohol use

FEMALES

Currently menstruating: Date of last menstruation: ____/____/_____

▢Normal cycles ▢Abnormal cycles, please explain: _____

No longer menstruating:

▢Natural menopause ▢Hysterectomy Date ____/____/_____ ▢Other _____

Are you breastfeeding or pregnant? ▢Yes ▢No

Are you using any type of birth control?
If yes, what kind and when did you start using it?_____

If not, are you interested in discussing birth control options during your visit? ▢Yes ▢No

Date of last PAP smear: ____/____/_____ Date of last mammogram: ____/____/_____

MALES

Date of last prostate exam: _____

Have you noticed any testicular pain or lumps/bumps? ▢Yes ▢No

If so, location _____ how long as this been present?_____

ALL

Date of last ▢Colonoscopy ▢Cologuard ▢FOBT: ____/____/_____

Last DEXA scan: ____/____/_____

Last eye exam: ____/____/_____ Performing provider: _____

Last annual wellness exam: ____/____/_____ Performing provider: _____

How often do you exercise? _____

Do you eat a well-balanced diet? ▢ Yes ▢ No

Are you on any special diet or dietary restrictions? _____

VACCINATIONS

Shingles ▢Yes ▢No

Influenza ▢Yes ▢No

Pneumonia ▢Yes ▢No

Tetanus, Diphtheria, Pertussis (Tdap) ▢Yes ▢No

Hepatitis A ▢Yes ▢No

Hepatitis B ▢Yes ▢No

COVID19 ▢Yes ▢No

Are you interested in receiving any vaccines during today's visit? ▢Yes ▢No

FAMILY HISTORY

Father: ▢Living ▢Deceased

History of: ▢High blood pressure ▢Diabetes ▢ Cancer, type: _____ ▢Stroke
Other _____

Mother: ▢Living ▢Deceased

History of: ▢High blood pressure ▢Diabetes ▢ Cancer, type: _____ ▢Stroke
Other _____

Other significant family history: _____

PREFERRED PHARMACY

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____