MARINER
ADVANCED PHARMACY CORP

PHARMACY SERVICES

ALLERGIES:_____

Name: _____ Date of Birth:_____

Address:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Please put a star next to your preferred contact phone number.

WORKER'S COMPENSATION (Please complete this section)

Date of Injury:_____ Claim #_____Adjuster Name: _____Phone_____

Compensation Carrier:_____Address_____

RxBin:_____RxPCN:_____ID#_____Group#_____

Employer: _____Address: _____Phone_____

PPO or HMO (Please complete this section)

Carrier_____Phone No:_____

RxBin:_____RxPCN:_____ID#_____Group#_____

Pharmacy Record Release Authorization

I, the undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to the above listed persons or organizations upon request or as deemed necessary. I understand that employees of Mariner Advanced Pharmacy Corp and affiliated provider and/or Consultant(s) will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide pharmaceutical care services to me. This authority shall continue until revoked by me in writing.

Physician Medical Release Authorization

I hereby authorize the above listed physicians or organizations to furnish Mariner Advanced Pharmacy Corp any and all records pertaining to my medical history, services rendered and/or treatments. I understand that employees of Mariner Advanced Pharmacy Corp and affiliated provider and/or Consultant(s) will protect my privacy and this information will be released to other health care providers only when it is necessary in order to provide health care services to me. I further understand that a Mariner Advanced Pharmacy Corp will not release this information unless authorized by me in writing as indicated above. This authority shall continue until revoked by me in writing.

Assignment of Claim

I hereby authroize my prescription(s) be sent to Mariner Advanced Pharmacy. I authorize payment for the prescription(s) rendered from my worker's compensation to be made directly to Mariner Advanced Pharmacy Corp. In the event of coverage denial AND if I choose to receive the prescribed medication(s), I understand that I am financially responsible for all charges associated. I further agree that a photocopy of this statement shall be as valid as the original.

Patient Signature: _____ Date: _____