

- DIRECTIONS:**
1. Return this form
  2. Return the Privacy form
  3. Attach prescriptions

**MADISON PHARMACY**  
 66 Main St.  
 Madison, NJ 07940  
 973-377-0075  
 973-377-1960 (fax)

**RETURN THIS FORM TO  
 MADISON PHARMACY**

*Insert Company Name Above*

**MADISON PHARMACY CORPORATE PROGRAM REGISTRATION FORM**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Cell Number: \_\_\_\_\_  
 \_\_\_\_\_ E-Mail:(for monthly specials) \_\_\_\_\_

**OFFICE / EMPLOYMENT INFORMATION...for local delivery**

Address: \_\_\_\_\_ Contact: \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 \_\_\_\_\_ Hours: \_\_\_\_\_

**ALLERGIES**

(Yes) Drug Allergies  Please List: \_\_\_\_\_  
 (No) Drug Allergies  \_\_\_\_\_

**PRESCRIPTION PLAN INSURANCE CARD**

**\*Please attach a legible copy front and back of your Prescription Plan Insurance Card or supply the following:  
 BIN #.....Pharmacy Group #.....ID#.....**

**CREDIT CARD INFORMATION**

Type of Credit card      **Visa**      **MC**      **Discover**      *(Please circle one)*  
 Name on Card \_\_\_\_\_  
 Billing Address of card \_\_\_\_\_ Billing Zip \_\_\_\_\_  
 Credit Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

**Name as it appears on card \_\_\_\_\_ I acknowledge and assume responsibility and grant authorization for Madsion Pharmacy to charge the above credit card. I also acknowledge responsibility for the cost of any medication not covered by my insurance company, for any medication that Madison Pharmacy cannot get reimbursement for, as well as any co-pays and deductibles and charges for requested OTC / Sundries which I agree will be billed to my credit card by Madison Pharmacy. I authorize Madison Pharmacy to contact my insurance company for insurance verification, billing, and collections for my medications. As per our HIPAA agreement all personal information received will be solely maintained for the purposes of dipensing prescriptions and insurance collection.**

**Signature of Guarantor:** \_\_\_\_\_