Blue River Pharmacy

26 S Green Street
Brownsburg, IN 46112
Phone: 317.286.3506
Fax: 317.350.2917

Medication Information

Current Pharmacy Name _____ **Phone #** _____

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Initial

Acknowledgment of Receipt of the Notice of Privacy Practice
Federal regulations require that Blue River Pharmacy obtain proof that customers have received the Notice of Privacy Practices. My signature indicates only that I have received a copy of Blue river Pharmacy's Notice of Privacy Practice, not that I have read it or agree with its contents.

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Initial

Notice of Non-Child Resistant Packaging
Regulations require that we dispense all oral medications in "child-proof" containers or systems. The Blue River Pharmacy strips and dispenser are NOT child resistant. By signing, you indicate that you are requesting a waiver of this regulation and that all medications are dispensed in a "non-child-proof" container or system until further written notice.

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Initial

Blue River Pharmacy Packaging Responsibilities
I understand that receiving Blue River Pharmacy packaging requires me to be involved in managing my medications. I will notify pharmacy staff members within an appropriate time period when my medications are changed, discontinued or when a new medication will start. I will work with Blue River Pharmacy to minimize wasting drugs that I currently have in my possession and to minimize insurance charges.

Terms of Benefits
The signed resident / patient / and / or legally responsible representative authorizes all providers of medical / drug benefits to the resident to pay Blue River Pharmacy directly for any benefits that the resident in entitled to for the services and products provided by Blue River Pharmacy; authorizes Blue River Pharmacy to release medical information related to the patient's care and to the patient's providers of medical or drug benefits so the Blue River Pharmacy can receive payment; and understands and agrees that, where permitted by law, he or she is personally responsible to pay Blue River Pharmacy for any services or products that are not paid for by the provider of any available medical or drug benefits.

_____
Signature of patient or responsible party

_____
Date