Island View Pharmacy

2038 West 1900 South
Syracuse, Utah 84075
Phone 801-773-7899 * Fax 801-773-7338
islandviewpharmacy@gmail.com

Bubble Pack Service Agreement

Island View Pharmacy provides compliance packaging services to the community. The pharmacy will bill your insurance provider or agencies according to the information you provide below. The Patient or guarantor will be responsible to pay the pharmacy directly for any deductibles, copays, co-insurance, or non-covered items.

Patient INFORMATION: (please print)

Name: _____ Date of Birth:_____ Allergies: _____

PRESCRIPTION/HEALTH INSURANCE INFORMATION:

The following information is required to properly bill insurance.
Name of patient as listed on insurance: _____
SS# (used to search/verify insurance):_____ Gender : M F
Insurance Company: _____
Address: _____
Policy Holder's Name:_____
RX BIN#:_____PCN#_____Rx Group#_____ ID#:_____ (Please send a copy of the pharmacy benefit insurance card, front and back)

GUARANTOR INFORMATION:

Name:_____SS#:_____
Relationship to student:_____ Phone number:_____
Mailing address_____St_____Zip_____

Email address:_____
Driver's license number:_____Issuing state:_____

METHOD OF PAYMENT: ( ) I give permission for Island View Pharmacy to charge my credit card each month for pharmacy services, including, but not limited to, medication, medical supplies, or medical equipment, as needed for the above mentioned patient/student.
Type of card:_____ Expiration date:_____ CVV/SVV#:_____

Card number _____

Cardholder's Signature:_____

GUARANTEE OF PAYMENT:

I, the undersigned, authorize Island View Pharmacy access to the above mentioned patient's/student's medical records for proper medication assessment. I agree to pay and guarantee the prompt payment of any indebtedness, obligations, and liabilities owing to Island View Pharmacy and/or it's agents for the above mentioned patient/student, including, but not limited to, medication, medical supplies, or medical equipment, as needed for the patient/student. I understand that prescription services may be suspended if payment is not made promptly and finance or interest charges at the rate of 18% per month will be charged if there is an unpaid balance. In addition, I understand and guarantee that I will be responsible to pay all attorney's fees, court costs, and cost of collections if the amount owed to Island View Pharmacy is not paid in a timely manner.

Guarantor Signature_____**Date**_____