VALLEY OF THE SUN PHARMACY

15600 N. Black Canyon Hwy Suite B135
Phoenix, AZ 85053
602-896-0454 phone 602-896-0456 fax

New Patient Consent and Payment Guarantee Form

Patient Name_____ DOB _____ Facility/Agency_____

Address_____ Phone_____

Allergies _____ Medical Conditions _____

Primary Care Provider _____ Phone _____

- □ Please transfer prescriptions from _____Pharmacy (Medication list Attached)
  Pharmacy Address_____ Pharmacy Phone_____
- □ Doctor will call/fax in new prescriptions
- □ Other _____

Rx Insurance Company _____ ID#_____ Phone_____

I authorize Valley of the Sun Pharmacy to request on my behalf all public and private insurance benefits for products/services supplied to me by the pharmacy. I further authorize payment for such products/services to be made directly to Valley of the Sun Pharmacy. *I will provide a copy of my insurance card (front and back) for billing purposes*.

**********Responsible Party Signature Required**********

Responsible Party (Print)_____ Responsible Party (Sign) _____

Billing Address_____ Phone_____

Card Type(circle one): VISA Mastercard Discover AMEX

Card Number: _____

Expiration Date (mm/yyyy) _____/_____ Security Code _____

Cardholder Name (as it appears on the card) _____

Authorized Amount: $_____

I certify that I am the authorized holder and signer of the credit card reference above. I certify that all information above is complete and accurate. I hereby authorize collection of payment for all charges as indicated above. Monthly charges may not exceed the amount listed above in the "AUTHORIZED AMOUNT" field without prior consent.

X_____ _____ _____

Signature Print Name Date