West Concord Pharmacy
1212 Main Street
Concord, MA 01742
Tel.: 978-369-3100
Fax: 978-371-1613
CONCORDMS@DINNOHEALTH.COM

# CONSENT FORM

***By signing the following document, the patient or the responsible party is authorizing West Concord Pharmacy, Inc. to:***

- ✓ **Receive and/or release any and all medical records and other necessary information pertaining to my healthcare. This consent could be shared with but not limited to physicians, hospitals, insurance companies, and other pharmacies when necessary.**
- ✓ **Some medications may be sent in Non-Childproof packaging.**
- ✓ **Bill me or the responsible party for my medications, supplies, or other services that I may receive from West Concord Pharmacy. These charges may include, but are not limited to, co-payments, deductibles, medications, purchases of over the counter items, and services not reimbursed by any other party.**
- ✓ **Authorize West Concord Pharmacy Inc. as requested through the Middlesex School Health Center.**

If you have any questions or need help with this form, please contact us and one of our staff will be happy to assist you.

Student Name: _____ Date: _____/_____/_____
(PLEASE PRINT)

Parent/Guardian's Signature: _____ Date: _____/_____/_____

Student or Responsible Party Signature: _____

**CREDIT CARD INFORMATION:**

1) Credit Card Account# _____
2) Name on Card _____
3) Expiration date _____
4) Security Code (on the back of the card) _____
5) Is this an HSA? _____

***We accept MasterCard, Visa, Discover, and American Express***

**Student or Guarantor Signature** _____**Date**_____

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# MEDICAL CONTACT INFORMATION

FACILITY NAME: ***Middlesex School***

PERSONAL:

NAME: _____ DATE OF BIRTH: _____

HOME PHARMACY NAME:_____

HOME PHARMACY PHONE:_____

FINANCIAL:

**PLEASE PROVIDE COPIES (BOTH SIDES) OF INSURANCE CARD(S)**

PRIMARY INSURANCE: _____

SUBSRBIER NAME & ID #: _____

BIN NUMBER: _____

PCN: _____

GROUP: _____

HEALTH:

**ALLERGIES**: (If none please indicate so)_____

PRIMARY PHYSICIAN: _____

ADDRESS & TEL #: _____

OTHER PHYSICIANS: _____SPECIALTY: _____

_____SPECIALTY: _____

_____SPECIALTY: _____

EMERGENCY CONTACT & TEL #: _____

*If you have any questions or need help with this form, please contact us. We will be happy to help you.*

***Please return all forms to our secure fax: (978)-371-6583***