



Sierra Specialty Pharmacy

9738 S. Virginia Street, #F

Reno, NV 89511

Phone: (775) 853-3502 Fax: (775) 236-5771

Billing & Consent Form

Facility/Group Home Name: Aurora Center for Healing

Delivery Address: 10 21st Street Hawthorne, NV 89415

Current Pharmacy Name, Location, and Phone Number:

Patient Information

Name:

DOB:

SS#:

Allergies & Diagnosis:

Primary Care Physician:

Billing Information

Name of Responsible Party:

Relationship to Patient:

Home Phone:

Cell Phone:

Billing Address:

City:

State:

Zip:

Credit Card # of Responsible Party:

Expiration Date:

CVV/CID:

Responsible Party Email (If Available):

Prescription Insurance Information (Please Provide Copy of Insurance Card(s))

Insurance Name:

ID/Member #:

BIN#:

PCN#:

Group#:



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I have read, understand and accept the following terms and conditions:

I agree to have Sierra Specialty Pharmacy fill and coordinate the care of my prescriptions through medication packaging, and delivery. There is no charge for the packaging or delivery.

I agree to pay all charges incurred by the above-named patient that are not paid for by third-party payers, including Medicaid/Medicare, and additional charges for specially-packaged medications.

I will pay the entire amount within 25 days of the statement date shown on the monthly billing statement.

I agree that in order for the patient account to remain active, payment for billed charges must be made promptly pursuant to these terms.

I agree to pay all costs of collection, including court costs and attorney's fees for all delinquent accounts/balances.

I understand that the medications furnished to the above-named patient are not, and will not be, packaged in child-proof containers.

I consent to the release of personal and medical information to any third-party payer, government agency providing health/prescription benefits, or any other person/entity responsible for my treatment charges. I consent to the release of all information as shall be necessary to initiate and continue my use of pharmacy, laboratory, or other similar community resources and/or transfer to another health care facility.

I certify that the information contained in this application is true and correct. I authorize verification of any and all of this information to include a check of credit.

You have permission to charge my credit card monthly to pay my statement.

Signature of Responsible Party _____ Date _____