

**□ ROUTINE MEDICATION SERVICE**

**□** **EMERGENCY FILL ONLY**

1030 Avenue D, Suite 2, Snohomish, WA 98290  
(P)360-863-3009 (F)360-217-7570 [www.matrxltc.com](http://www.matrxltc.com/)

# New Patient Information

Patient Name: Gender: M F DOB: / /

Community/Agency: Social Security Number:

**Prescription Insurance Information** (attach card copy) □ Medicare □ Medicaid □ Other

Insurance Name Contract Number

(ID #)

Bin BIN# PCN# RX Group #

**Allergies:**

**Medical Conditions:**

# Responsible Party for Billing Information

Name: Relationship:

Address: City: State: Zip:

Phone Number (not facility): Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that I am responsible for all pharmacy charges for the above resident which are not covered by private insurance or Medicaid. I agree to pay statement balances on receipt unless other arrangements are made. Late payments of 30 days or longer will bear interest at rate of 12% per annum.

I agree to allow staff at the facility to act as my agent in both ordering and receiving medications.

I acknowledge that I have received a copy of the notice of privacy practices.

I request that my prescriptions be packaged in standard containers **without** child resistant safety caps.

Signature Date

A credit card or voided check is **required**, and will be charged if no payment(s) or arrangement(s) for payment have been made for charges 30 days past due. **FOR AUTOMATIC PAYMENT PLEASE COMPLETE ATTACHED FORM.**

Form of Payment: □ ACH **(Please provide a voided check)**

* Visa □ MasterCard □ American Express □ Discover

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Number: \_\_\_\_\_\_\_\_\_\_\_ Expiration:

Signature: Date:

Revised 08/2018





