PATIENT CONSENT FORM

ALL RESIDENTS COMPLETE THIS SECTION

COMMUNITY: _____

RESIDENT NAME: _____

RESPONSIBLE PARTY: _____

ADDRESS: _____

CITY AND STATE: _____

TELEPHONE: _____

Carmichael Long Term Care Pharmacy (CLTCP) is available 24 hours a day, seven days a week to meet resident's needs. Each resident has the right to select the pharmacy of his or her choice. CLTCP has a pharmacy computer system, which enables the pharmacist to keep accurate records on each resident. This system provides the pharmacist with valuable information such as resident allergies and drug interactions. This system also provides the resident with a detailed statement of all items billed.

If you wish to take advantage of the services of CLTCP, please sign under the box marked YES.

YES , I wish to enlist the services of CLTCP and agree to pay CLTCP for any pharmacy products.

_____ _____

Responsible Party/Resident's Signature Date Signed

NO , I do not enlist the services of CLTCP, I will be using _____

_____ _____

Responsible Party/Resident's Signature Date Signed

PLEASE COMPLETE THE FOLLOWING FOR RESIDENTS WITH INSURANCE

A medication that is prescribed to you may not be covered by your insurance. If the medication is not covered, the resident is responsible for payment.

YES , I agree to pay CLTCP for any medications and other pharmacy products not covered by the resident's insurance program.

_____ _____

Responsible Party/Resident's Signature Date Signed

NO , I will not pay CLTCP for any medications and other pharmaceutical products not covered by the Resident's insurance program.

_____ _____

Responsible Party/Resident's Signature Date Signed