Gordon Family Pharmacy
Phone: 828-877-6111
Fax: 828-877-6487
Email: gordonfamilypharmacy@gmail.com

High Rocks

518 S Broad St.
Brevard, NC
28712

Pharmacy Form

We will do our best to process prescription(s) through your insurance, but please understand that some insurance companies do not contract with all pharmacies. You are fully liable for any balance not paid by your insurance. We can not process prescriptions through your insurance without a copy of both sides of your insurance card. The $20 fee Gordon Family Pharmacy charges for bubble packing is not covered by any insurance.

All fields are required:

Camper's First and Last Name: _____

Gender: Male | Date of Birth: _____

Street Address: _____

City/State/Zip Code: _____

Drug Allergies: _____

_____

Name of Current Pharmacy: _____

Current Pharmacy Phone Number: _____

Insurance Company: _____

Name of Cardholder: _____

Primary Address of Cardholder: _____

_____

Member or Cardholder ID #:_____Rx Group #: _____

Rx BIN #:_____Rx PCN #: _____

**** Please attach a copy of both sides of the insurance card with this form.***

Parent/Guardian Full Name: _____

Phone Number: _____

If I am submitting insurance information, I agree to authorize Gordon Family Pharmacy to contact my insurance company for insurance verification, billing and collections for my child's medication. Our licensed Pharmacy is HIPAA compliant and all personal information received will be solely maintained for the purpose of filling prescriptions and processing insurance claims.

Parent/Guardian Printed Name: _____

Signature:_____Date: _____

2021 Session: Three Week ❑ Four Week ❑ Mini I ❑ Mini II ❑ August Two Week ❑ Junior Camp ❑

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Payment Agreement

We require that you submit a credit card number to cover all medications and the $20 bubble packing fee. Our Pharmacy does not accept American Express.

Name on the Card: _____

Credit Card Number: _____

Expiration Date:_____ CVV #: _____

Credit Card Type:_____ Zip Code: _____

I acknowledge that I am responsible for the cost of any medication not covered by my insurance company, for any medication the pharmacy cannot get reimbursed for, as well as any co-payments, deductibles, and charges for over the counter medication authorized to be charged. Our licensed Pharmacy is HIPAA compliant and all personal information received will be solely maintained for the purpose of filling prescriptions and processing insurance claims and payments.

Parent/Guardian Printed Name: _____

Signature:_____Date: _____

Please feel free to contact Gordon Family Pharmacy with any questions or concerns you may have.

Please send this form back to Gordon Family Pharmacy via email, fax, or mail.