Pharmacy Enrollment Form
General Information

Today's Date *

Patient Name *

First: | Last:

What name do you go by?

If you are assisting in filling out this form, please enter your name here

First: | Last:

What is your date of birth? *

Assigned Sex at Birth?

◯ * Male ◯ Female ◯ Unassigned

What is the best number to reach you at? *

What type of phone is this? *

◯ Cell Phone ◯ Home Phone ◯ Work ◯ Other

Please identify who the number belongs to *

Do you have any drug allergies? *

◯ Yes ◯ No

Please list any drug allergies in the space below *

What is your Social Security Number? *

What is your current home address? *

Address Line 1:

Address Line 2:

City: | State: | Zip Code:

Please enter your Driver's License number

JTJ Medical Supply, Inc. Communication Preferences

Patient Name *

First:

Last:

How should we contact you? *

◯ Cell Phone ◯ Home Phone ◯ Work Phone ◯ Other

Mail-Meds Clinical Pharmacy may deliver your medications and information about your medications.*

◯ Yes ◯ No

If you do not answer the phone, may we leave a message with a name and call back phone number? *

◯ Yes ◯ No

Where would you like your medication and information about your medication delivered to? *

◯ Home ◯ Work ◯ Doctors Office ◯ Other

If you selected other, please provide address for delivery *

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Do you have an emergency contact? *

◯ Yes

◯ No- I decline to provide an emergency contact

What is your emergency contacts name? *

First

Last

What is your relationship to emergency contact? *

i.e. partner, parent, friend

What is the best phone number to reach your emergency contact? *

Do you have a primary caregiver? *

◯ Yes ◯ No, I do not have a primary caregiver

What is your primary caregivers name? *

First

Last

What is your relationship to primary caregiver? *

What is the best phone number to reach your primary caregiver? *

Use this space to provide the first and last name, relationship and phone number of people we are authorized to share and release your information to.

Do you have a case manager? *

◯ Yes ◯ No

What is your case managers name? *

Although SMS/text messages communicated wirelessly are usually encrypted by the carrier, interception and decryption of such messages may be done.Text messages reside on a mobile device and carrier's server indefinitely where the information may be exposed to unauthorized third parties due to theft,loss, or recycling of the device. By checking YES above you understand that texting is not a secure form of communication. Please approve or deny consent below. *

◯ I consent to receiving SMS/text messages from Mail-Meds Clinical Pharmacy

◯ I do not want SMS/text messages

Please enter your cell phone number if you would like to receive text messages *

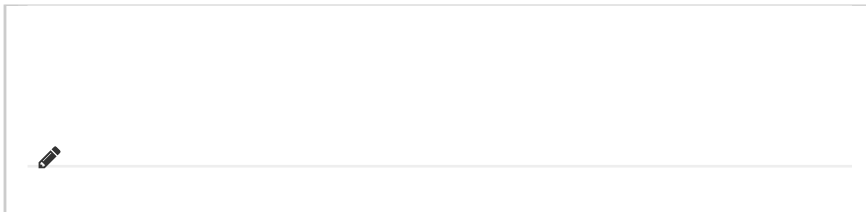
If we are emailing protected information we will use encrypted email service that is a secure form of communication. There is some risk that any individuallyidentifiable health information and other sensitive or confidential information that may be contained in any email may be misdirected, disclosed to orintercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information (PHI) in any communication. Our first email to you will verify the email address you provide to us. Please approve or deny consent below.*

◯ I consent to receiving emails from Mail-Meds Clinical Pharmacy

◯ I do not want emails

Please enter your email address if you would like to receive emails *

By signing in the space provided, I certify all information is true and correct to the best of my knowledge. I acknowledge that I have authorized Mail-Meds Clinical Pharamcy to use of all information provided to communicate with me in the methods indicated above. Please sign below. *



Date *

Pharmacy Services and Preferences Questionnaire

Patient Name *

First: | Last:

What language do you speak most often with your friends and family? *

◯ English ◯ Spanish ◯ Creole ◯ Other

Would you like an interpreter to assist you to clearly understand about our pharmacy services? *

◯ Yes ◯ No

Do you have any visual difficulties that require large printed information or talking labels? *

◯ Yes, I would like large printed information

◯ Yes, I would like talking labels

◯ Yes, I would like both large printed information and talking labels

◯ Yes, I would like my information printed in brail

◯ No, I do not have any visual difficulties

Are you able to read and understand the directions on a bottle of medicine? *

◯ Yes ◯ No

Do you have any cultural, religious beliefs, or preferences about your health care that you would like us to know to service you better? *

◯ Yes ◯ No

If yes, please describe how the you manage them, what remedies have been tried, and the health outcomes. Please include the names and type of practice of any doctors or other healthcare professionals involved in your health treatment. *

Please specify your most spoken language in the space below *

What language would you like us to print your prescription labels and medication education materials in?*

◯ English ◯ Spanish ◯ Creole ◯ Other

Please specify what language you would like your prescription labels and medication education materials printed in *

Please describe *

What is your gender identity? *

◯ Male

◯ Female

◯ Trans man (female to male)

◯ Trans woman (male to female)

◯ Nonbinary

◯ Other

◯ Declined to answer

What is your sexual orientation?*

◯ Heterosexual/Straight

◯ Gay

◯ Lesbian

◯ Bisexual

◯ Pansexual

◯ Asexual

◯ Other

What are your preferred pronouns? *

◯ He, Him, His She,

◯ Her, Hers They,

◯ Them, Their

Please use the space provided to tell us anything else about you that you would like to share.

JTJ Medical Supply, Inc. Financial Information

Patient Name *

First: | Last:

Including yourself, how many people live in your household? *

What is your approximate annual gross HOUSEHOLD income?*

Are you a legal US resident? *

○ Yes ○ No

Do you have insurance coverage? *

○ Yes ○ No

Who is your doctor or provider? *

Please list any other doctors or providers you are seeing.

Please enter the name of your Insurance provider

Please enter your member ID number located on your insurance card

Please enter the Rx Bin number located on your insurance card

Please enter the Rx Group number located on your insurance card

By signing in the space provided, I certify all information is true and correct to the best of my knowledge. I acknowledge that I have authorized Mail-Meds Clinical Pharmacy the use of all information provided to apply for financial assistance if needed. *

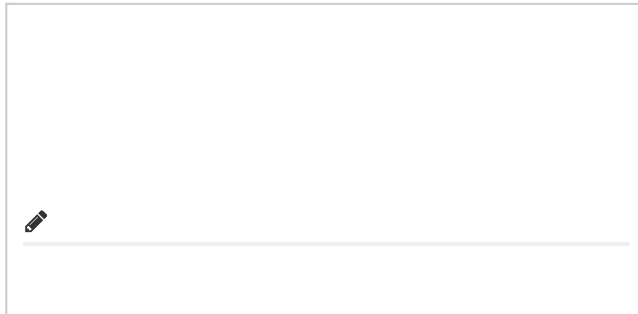
Date *

JTJ Medical Supply, Inc. Assignment of Benefits

Patient Name *

First: | Last:

I hereby authorize Medicare, Medicaid or my private health insurance plan to pay my drug and supplies benefit directly to JTJ Medical Supply, Inc. I authorize JTJ Medical Supply, Inc. to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I further authorize any holder of medical information about me to release such information that may be required for JTJ Medical Supply, Inc. to file an insurance claim on my behalf. The original will be kept on file by JTJ Medical Supply, Inc. and a copy sent to my insurance plan when requested. Patient Responsibility: I agree that my insurance company's verification of benefits does not release me from financial responsibility for services rendered. If my insurance company denies any claims, in part or whole, to include any deductible, co-insurance, co-payment or disallowance of payment, or the organization is an out-of-network provider, I am financially responsible for all charges not covered by my insurance. I understand the actual member financial responsibility will be determined when the claim is processed and I will be contacted by a JTJ Medical Supply, Inc. staff informing me of the cost prior to the delivery of the medication(s) and the costs will be provided to me both verbally and in writing. In the event of non-coverage, or if my insurance should pay benefits directly to me for any merchandise provided by JTJ Medical Supply, Inc., I will either endorse all checks from my insurance company as "Pay to the order of JTJ Medical Supply, Inc." within seven (7) days of receipt of checks or provide payment to JTJ Medical Supply, Inc. in the form of a personal check or credit card. I agree to inform JTJ Medical Supply, Inc. of any change in my status including, but not limited to: change in address, hospital or nursing home admissions and discharges, and any changes that affect my insurance coverage and payments or my own ability to pay for products and services rendered by JTJ Medical Supply, Inc. and prescribed by my physician. If you have any questions regarding this form, please contact JTJ Medical Supply, Inc. at 2692 Oak Ridge Court, Fort Myers, FL 33901, (800) 939-2022. Please sign below *



Date *

JTJ Medical Supply, Inc. HIPAA Privacy Notice

Patient Name *

First: | Last:

As required by HIPAA, all Patients who receive pharmacy services from JTJ Medical Supply, Inc. must sign below.Please note that the attached Notice is not a consent form. This form must be read in full and signed before services can be provided. This Notice provides our Patients with a summary description of
(1) How our office will use and disclose medical and billing information for legitimate business purposes, and
(2) How our Patients can exercise their rights with regard to his/her health information.

This notice is similar to the one that you receive from your physician's office and other institutions that provide medical care and services. Please confirm you have received the JTJ Medical Supply, Inc. Notice of Privacy Practices by signing below.

Thank you!I have received the JTJ Medical Supply, Inc. Notice of Privacy Practices in the Enrollment/Welcome Packet/ Handbook. By signing below I acknowledge that I have received the JTJ Medical Supply, Inc. Notice of Privacy Practices in the Enrollment/Welcome Packet/Handbook. *

Date *

JTJ Medical Supply, Inc. Welcome Packet Acknowledgment

Patient Name *

First: | Last:

I acknowledge that I received the Welcome Package that contains at least the following information:

1) Contact Information
2) Hours of Operation
3) Clinical Pharmacist After Hours Availability
4) Patient Clinical Management Program
5) Patient Bill of Rights and Responsibility
6) Patient Complaint Form
7) Request of Financial Assistance Information
8) Assignment of Benefits Form
9) Disposal of Medical Waste Clinical Management standards
10) Patient Contact and Communications Consent
11) Notice of Privacy Practices
12) Customer Satisfaction Form.

Please confirm you have received JTJ Medical Supply Specialty Pharmacy Welcome Packet by signing in the space provided. *

Date *

JTJ Medical Supply, Inc. Authorization to Obtain Confidential Information

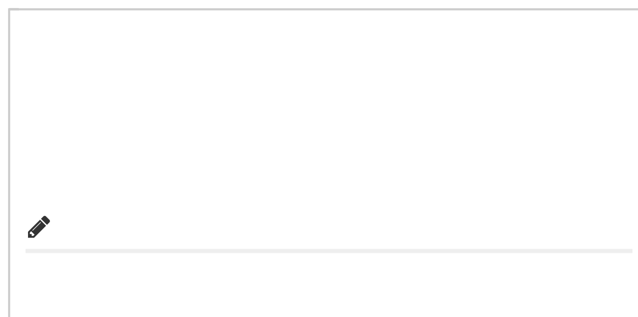
Patient Name *

First: | Last:

Please specify the name of the entity or provider we may obtain the information listed below.

INFORMATION MAY BE DISCLOSED TO: Mail-Meds Clinical Pharmacy 2692 Oak Ridge Court, Fort Myers, FL 33901 Phone #: (800) 939-2022Fax #: (855) 523-0910 I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:
1) General Medical Records
2) Progress Notes
3) History and Physical Results
4) Treatment Plans
5) Most Recent Laboratory Results I understand that if I refuse to sign this Authorization, it will not affect my ability to receive treatment, payment or eligibility of benefits. This can affect the following if refused:
• If the treatment is research-related
• If it is used to determine eligibility for enrollment into a health plan or if a benefit payer is utilized.
• If the sole purpose of the Authorization is to create Protected Health Information that will be disclosed to third-party.
• If the recipient is not covered by the HIPAA Regulations, then the information disclosed may not be further protected.

By signing below I understand that I may revoke this authorization at any time by contacting the Mail-Meds Clinical Pharmacy Administrative department by calling 800-939-9226 and select option 4 to request a written authorization to revoke this acknowledgement. By signing below, I acknowledge this authorization of use and/or disclosure for up to a year after the written date.



Date *