

# Ed's Pharmacy

3740 Cartwright Rd  
Missouri City, TX 77459  
(281) 499-4555  
Fax: (281) 499-7088

## Pharmacy Agreement Form as of 6/23/04

### Patient Information

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PLEASE PRINT CLEARLY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Personal Care Facility \_\_\_\_\_

PHARMACY insurance \_\_\_\_\_ Group \_\_\_\_\_

ID \_\_\_\_\_ \*\*\*Copy of the Card is Also Needed for Our Records

Texas Drivers License Number or Identification number \_\_\_\_\_

### Responsible Individual Information

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Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Texas Drivers License Number or Identification number \_\_\_\_\_

### Payment Plans

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Ed's Pharmacy can bill on a 30 day account OR by a major credit card that is kept on file. Please select one:

*Credit Card Option:* Card # \_\_\_\_\_ Exp \_\_\_\_\_  
(if paying by Credit Card Plan)

*In-Store-Charge Account Option.* I choose to use the 30 Day In-Store-Charge Account which will be billed to me at the end of each month and is payable by the 10<sup>th</sup> of the following month.

### Agreement

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I acknowledge that I am the responsible individual for the patient listed above, and I agree that Ed's Pharmacy may contact me to obtain needed information. I grant permission for Ed's Pharmacy to charge my account in the method selected above for prescriptions and health care items ordered for the patient by the patient's personal care facility, and I agree to pay for such reasonable charges.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_