Indiana University Health

IU Health Advanced Therapies Pharmacy
355 W. 16th St. Suite 1600 GH 1074
Indianapolis, IN 46202-2278
Phone: 317.963.7100 **Toll Free:** 844.678.7100

Patient Enrollment Form

Need to send us a paper prescription? Please print this form and mail to us along with your **original** paper prescriptions. We will process your order and deliver to your address free of charge. Use this form if you are a new IU Health Advanced Therapies Pharmacy Mail Order patient.

Please complete all fields for up to three family members, then print and mail with **original** prescriptions to the address above.

Section 1: Patient Information & Allergies

_____ _____ _____ ☐ Male ☐ Female
Patient 1 First Name | Patient's Last Name | Patient's Date of Birth

☐ No Known Allergies _____
List any drug allergies and any reaction you had. Include over-the-counter medications.

Section 2: Delivery Information

_____ _____ _____ _____ _____
Street Address | Apartment/Ste. | City | State | Zip Code

_____ _____ _____
Daytime Phone Number | Evening Phone Number | Email Address

Preferred Contact Method: _____

***Please note that the pharmacy will not ship any medications if they are unable to contact you.**

Section 3: Prescription Insurance Information

Provide the information below as found on your prescription benefit card and you can include a photo-copy of the front & back of your prescription benefit card.

_____ _____ _____ _____ _____
Name of Insurance or Health Plan | Identification Number | Group Number | Bin | PCN

☐ Cardholder ☐ Spouse ☐ Dependent

_____ _____ _____
Cardholder's First Name | Cardholder's Last Name | MI

_____ _____ _____ _____ _____
Name of Secondary Insurance or Health Plan | Identification Number | Group Number | Bin | PCN

☐ Cardholder ☐ Spouse ☐ Dependent

_____ _____ _____
Cardholder's First Name | Cardholder's Last Name | MI

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Section 4: Payment Information

CREDIT CARD: For your safety we do not collect credit card numbers on this form. If you would like to pay by credit card please contact our team directly to add the credit card information to your account. Orders will not ship until a form of payment is on file. Credit card will be used for the entire co-pay and any future orders until a new form of payment is specified. **By signing in the Patient Signature for Credit Card, you are authorizing IU Health Advanced Therapies Pharmacy to charge any balances, deductibles or co-pays due.**

We accept Discover, Master Card, Visa, FSA and HSA cards.

☐ Pay by Credit Card Best contact number: ( ) _____ - _____ Patient Signature for Credit Card: _____

IU HEALTH EMPLOYEE PAYROLL DEDUCTION: By signing, I certify that I am actively employed at IU Health. I authorize deduction from my paycheck the sum of the co-pay incurred from use at an IU Health Pharmacy.

☐ IU Health Employee Payroll Deduction Employee ID _____ Employee Signature _____

Please note that you will be contacted if your prescription costs more than $100 or has an increase in copay amount of $50.

Section 5: Prescription Information - New or Transfer prescriptions

New or transfer prescriptions? If you have additional prescriptions you would like to transfer to IU Health Advanced Therapies Pharmacy, please complete the sections below. We will contact your doctor or current pharmacy and transfer your prescriptions. *It's as easy as that!*
Please note, if your current prescriptions do not have remaining refills we will need to contact your doctor which can cause a delay.

Patient Name: _____ Patient's Date of Birth: _____

_____ Medication Name/Prescription Number	_____ Doctor or Pharmacy Name & Phone Number
_____ Medication Name/Prescription Number	_____ Doctor or Pharmacy Name & Phone Number
_____ Medication Name/Prescription Number	_____ Doctor or Pharmacy Name & Phone Number

**We will make every effort to fill a 90-day supply for maintenance medications. Please know there are some medications that your insurance may limit to 30-day supply. Additionally, if the prescriptions transferred to our pharmacy are for 30 days or do not have adequate refills remaining for 90 days we will ship a 30 day supply for the first fill and work with your doctor to secure an appropriate prescription for fills going forward. Please let our staff know if you do not wish to fill 90 day supplies of your maintenance medications.*

I authorize IU Health Advanced Therapies Pharmacy to mail prescription medicine directly to the location I have specified. I certify that all the information on this form is correct. I permit IU Health Advanced Therapies Pharmacy to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Authorized Signature: _____ Date: _____

I authorize IU Health Advanced Therapies Pharmacy to leave any supply or product order in a designated area if I am not home to accept the delivery. **Disclaimer IU Health Advanced Therapies Pharmacy is not responsible for any damages or lost or stolen items, if you are opting into this option.*

Authorized Signature: _____ Date: _____

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Section 6: Calling, E-mail or Text Reminders

In an effort to communicate in a more efficient and timely manner with our patients, IU Health Advanced Therapies Pharmacy has the ability to use email and text communication to contact our patients regarding non-urgent messages. These communications will include but not be limited to: prescription status and if there was an issue with your prescription order.

Please sign me up to receive information & alerts from IU Health Advanced Therapies Pharmacy via text messages. I understand this program is completely voluntary and that text messaging rates & fees may apply as determined by my cellular provider. The IU Health Advanced Therapies Pharmacy is in no way responsible for any fees charged to me by my cellular provider. If at any time I wish to discontinue receiving phone, email and text messages from IU Health Advanced Therapies Pharmacy, I must contact the IU Health Advanced Therapies Pharmacy staff in order to discontinue this service.

- ☐ Check here to opt-in to receiving phone call alerts
- ☐ Check here to opt-in to receiving email alerts
- ☐ Check here to opt-in to receiving text alerts

Patient Name: _____

E-mail Address: _____

Cell Phone Number: _____

Patient Signature: _____

Date: _____

Thank you for choosing IU Health Advanced Therapies Pharmacy. If you have any questions or concerns or would like to speak to a pharmacist, please contact us at (317) 963 – 7100 or toll-free at (844) 678 – 7100.

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PATIENT E-MAIL/TEXT USAGE CONSENT

(CONSENT REQUIRED FOR PROVIDER/PATIENT E-MAIL/TEXT COMMUNICATION)

As a patient, I find it beneficial to communicate with my healthcare provider *(specify name below)* _____via electronic mail/text (e-mail). E-mail/text can be a valid, simple, convenient and inexpensive mechanism for communication and can be an aid in the healthcare delivery process.

Types of Permitted E-mail/Text Transmissions: The types of information that can be communicated via e-mail/text with the provider include, but are not limited to, prescription appointment scheduling requests, billing/insurance questions/answers, and patient education. If I am not sure if the issue I wish to discuss should be included in an e-mail/text to the provider, I will call the provider's office to schedule an appointment.

Fees: Fees may be assessed for any communications or consultations with the provider via e-mail/text; however, no fee shall be assessed for questions involving general information such as clinic hours, location of clinic, appointment scheduling requests, and billing/insurance questions/answers. *Provider to list applicable fees that may be assessed for on-line consultation:* _____

Alternate Forms of Communication: I understand that I may also communicate with the provider via telephone or during a scheduled appointment and that the e-mail/text is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive medical information.

Emergency Situations: E-mail/text should never be used for emergency situations or urgent problems. In the event of an emergency, I will call 911 or go to an emergency room, urgent care or immediate care facility.

Risks of Using E-mail/Text to Communicate With My Provider: Transmitting patient information by e-mail/text has a number of risks that I will consider before using e-mail/text to communicate with the provider. These include, but are not limited to, the following:

- E-mail/text can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail/text can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail/text senders can easily type in the wrong e-mail address or wrong phone number.
- E-mail/text is easier to falsify than handwritten or signed documents.
- Back-up copies of e-mail/text may exist even after the sender or recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails/text transmitted through their systems.
- E-mails/text can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail/text can be used to introduce viruses into computer systems or cellular phones.
- E-mail/text can be used as evidence in court.

Security Measures Taken by IU Health: IU Health uses the following security measures among others to ensure the security of protected health information.

- Patient-identifiable information is never forwarded to a third party except for treatment, payment or healthcare operations purposes, without the patient's express permission.
- Patient's e-mail addresses or phone numbers are never used for marketing purposes without the patient's permission.
- Professional e-mail accounts are not shared with patient's family members.
- E-mails/texts are backed-up and archived on a regular basis.
- E-mail/text recipient e-mail addresses and phone numbers are verified prior to sending the message with a confidential indicator attached for the recipient.

Hold Harmless: I agree to indemnify and hold harmless the provider, his or her medical practice, IU Health, and its trustees, officers, directors, employees, agents, information providers, suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney fees, relating to or arising from any information loss due to technical failure, my use of the Internet to communicate with the provider, the use of the provider's website, any arrangements I make based on information obtained at the site, any products or services obtained through the site, and any breach by me of these restrictions and conditions. The provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the provider's website or server that makes such site available is free of viruses or other harmful components.

Forwarding E-mails/Text: I understand there may be times in which the provider must forward the information I have provided via e-mail/text to a third party for treatment, billing or payment purposes. I expressly provide my consent to allow the provider to forward these e-mails/text to a third party under these conditions and evidence my consent by placing my initials here:__***(Initial if you agree.)***

Termination of the E-mail/Text Relationship: I have the right to revoke this consent, in writing, at any time by presenting the written revocation to my healthcare provider. The provider shall have the right to immediately terminate the e-mail/text relationship with me if he or she determines, in his or her sole discretion, that I have violated the terms and conditions set forth in the Agreement or have engaged in conduct which the provider determines to be unacceptable.

Patient Acknowledgement and Agreement: I hereby consent to the use of e-mail as a means of communication between an IU Health Provider and me. I have discussed this form with the provider, understand the inherent limitations related to electronic communications, understand the limits of e-mail transactions and text messaging, hold harmless IU Health for loss of information due to technical failures and consent to these conditions and terms.

Patient Name *(printed):*_____

E-mail: _____ Phone Number: _____

Patient/Legal Representative Signature:_____Date:_____