Prescription Solutions Mail Service Pharmacy Prescription Order Form

Customer Information

Last Name | First Name | Member ID # (if applicable)

Mailing Address | City | State | Zip Code

( ) Day Time Phone Number | ( ) Night Time Phone Number | Email Address | # of Prescriptions Enclosed | $ Total Amount Enclosed

Date of Birth (MM-DD-YYYY) | Jean-Claude Hage, M.D. Physician Name | (909) 886-4917 Physician Phone Number

Confidential Patient Profile

This form only needs to be completed for first time orders or if any of the relevant information has changed since your first order. Please complete this form and return it with your original prescription(s). To allow us to monitor for potential drug interactions, please indicate any drug allergies below. Please fill out the grid below completely. **This form must be completed to process your first order.**

Allergies

- ☐ Ampicillin
- ☐ Aspirin
- ☐ Cephalosporins
- ☐ Codeine
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracyclines
- ☐ No known allergies
- ☐ Other (specify) _____

Auto Refill Program (Birth Control Pills)

☐ Check here to enroll in the automatic refill program for your birth control pills. To participate in this program, you must include your credit card number and expiration date in the space below. By enrolling in this program, your prescription medication(s) will be sent to your address on file. You should receive your prescription(s) when you have approximately a 7-day supply of medication(s) on-hand. You authorize us to charge your credit card for all applicable fees and charges. If you no longer wish to participate in the automatic refill program for your prescription(s), you must notify Prescription Solutions by calling 1-800-562-6223.

Payment Information

Please select method of payment below. **Do not send cash**. Enclose total payment for all prescriptions ordered.

☐ CHECK OR MONEY ORDER (Payable to Prescription Solutions)

For Credit Card orders (select one): ☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Credit Card Number ____ – ____ – ____ – ____ Expiration Date __ – __

I certify the information on this form is correct. I assume financial responsibility for these charges. Payment in excess of amounts due will be applied to my account. If method of payment is not indicated, I authorize Prescription Solutions to apply the charges to my credit card on file.

Cardholder Name | Cardholder Signature

➢ **Send via U.S. Mail to: Prescription Solutions, P.O. Box 509075, San Diego, CA 92150-9075**

Be sure to include this order form and your original prescription(s). Please call 1-800-562-6223 with any questions.

Visit our web site at www.rxsolutions.com