Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

PATIENT ENROLLMENT FORM

Health Spectrum Pharmacy Services

We are able to offer convenience shipping Monday through Friday when you reorder your prescriptions online or by calling and using the Interactive Voice Response system and indicating that you request the medication(s) be shipped. When your order is processed we will send you an email with a tracking number. Shipping charges will be based on the United States Postal Services prevailing rates plus a packaging fee. Most packages will be sent first class mail with a 2-3 day delivery time. Refrigerated items will not automatically be shipped – for more information, please call the pharmacy. Prescriptions sent to your home are non-returnable. Be sure to submit refills at the same time in order to avoid multiple shipments and charges.

**** Please ensure that Patient 1 is the main cardholder. They will become the main shipping contact. ****

Section 1: Patient Information & Allergies

If additional space is needed, please continue on a second form.

Patient 1 _____ (First Name) _____ (Last Name) ___/___/___ (Date of Birth) ☐ Male ☐ Female ☒ Cardholder

☐ No Known Allergies _____

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 2 _____ (First Name) _____ (Last Name) ___/___/___ (Date of Birth) ☐ Male ☐ Female ☐ Spouse ☐ Dependent

☐ No Known Allergies _____

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 3 _____ (First Name) _____ (Last Name) ___/___/___ (Date of Birth) ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 4 _____ (First Name) _____ (Last Name) ___/___/___ (Date of Birth) ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 5 _____ (First Name) _____ (Last Name) ___/___/___ (Date of Birth) ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 6 _____ (First Name) _____ (Last Name) ___/___/___ (Date of Birth) ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____

List any drug allergies and any reaction you had. Include over-the-counter medications.

Please complete the “Delivery & Contact Information” and “Payment Information” sections located on page 2.

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Section 2: Delivery & Contact Information

Primary Address: (Patient 1's name will be utilized),

Street Address	Apartment/Ste.	City	State	Zip Code

☐ Cell ☐ Home ☐ Work (Daytime Phone Number)

☐ Cell ☐ Home ☐ Work (Evening Phone Number)

Email Address

Secondary Address: (college, 2nd home, caretaker, etc…) **Dates:** / / **to** / /

Street Address	Apartment/Ste.	City	State	Zip Code

☐ Cell ☐ Home ☐ Work (Daytime Phone Number)

☐ Cell ☐ Home ☐ Work (Evening Phone Number)

List Patient(s) At This Address When In Use

Tertiary Address: (college, 2nd home, caretaker, etc…) **Dates:** / / **to** / /

Street Address	Apartment/Ste.	City	State	Zip Code

☐ Cell ☐ Home ☐ Work (Daytime Phone Number)

☐ Cell ☐ Home ☐ Work (Evening Phone Number)

List Patient(s) At This Address When In Use

Section 3: Payment Information

This payment information will apply to all patients listed in Section 1

Please provide your regular credit card info and, if enrolled, your healthcare flexible spending (FSA) credit card info:

Credit Card Number | / Expiration Date | Name on Card | ☐ Visa ☐ Amex ☐ MasterCard ☐ Discover

FSA Card Number (if applicable) | / Expiration Date | Name on Card | ☐ Visa ☒ FSA ☐ MasterCard

By signing, I certify that I am authorizing Health Spectrum Pharmacy Services to charge the credit card(s) listed above and any subsequent cards that are provided for the cost of the prescriptions and any shipping fees that are incurred by utilizing this convenience shipping services. I also certify that I have received, read and understand all of the provisions and guidelines contained on this form and on the accompanying Convenience Shipping Information form. Prescriptions will not ship unless payment is made and are non-returnable.

Name (Please Print) | Signature | / / Date

Health Spectrum Pharmacy Services

Convenience Shipping Information

Who – available to all Health Spectrum Pharmacy Services customers

What – a home shipping service for prescription refills

When – it starts as soon as you sign up

Where - stop in at any Health Spectrum Pharmacy Services Location to sign up

You will need to provide:

- Credit card Information (regular and FSA, if you are enrolled in the LVHN healthcare flex program)
- Email Address for shipping confirmation messages
- Phone Contact
- US Postal Address(es)
- You agree to being charged your co-pay and the shipping fee for all the prescriptions you request to be shipped. Prescriptions sent to your home are non-returnable.

Guidelines

We are able to offer convenience shipping Monday through Friday when you reorder your prescriptions on-line or by calling and using the Interactive Voice Response system and indicating that you request the medication(s) be shipped.

When your order is processed we will send you an email with a tracking number.

By default, shipments will be sent using the name of Patient 1 and the primary address listed. If an alternate address is used, the first name listed for that location will become the ship-to contact.

Shipping charges will be based on the United States Postal Services prevailing rates plus a packaging fee. Most packages will be sent first class mail with a 2-3 day delivery time.

New prescriptions and refrigerated items will not be automatically shipped – *why not?*

- We do not know if you need the prescription urgently and want to pick it up.
- The prescriber may send a prescription that you decide against - you would be charged for the shipping and co-pay.
- We do not know if someone will be home to receive the refrigerated item.

Prescriptions sent to your home are non-returnable.

Be sure to submit refills at the same time in order to avoid multiple shipments and charges.