Eaton Apothecary

Application for Charge Account

PLEASE PRINT CLEARLY

Origin Store # 3085

REQUIRED DOCUMENT 1 OF 2

CLIENT INFORMATION

First Name (OF PERSON RECEIVING MEDICATION)	*Last Name*	
Delivery Address (WHERE MEDICATIONS WILL BE SENT)		*Unit #*
Delivery City	*State*	*ZIP*
Phone #	*Date of Birth*	*SSN*

BILLING/STATEMENT MAILING INFORMATION

First Name (OF PERSON TO RECEIVE STATEMENT)	*Last Name*		
Address (WHERE STATEMENT WILL BE SENT)			
City	*State*	*ZIP*	*Phone #*

PAYMENT OPTIONS

☐ **AUTOPAY WITH PAYMENT CARD** - *(Please provide payment card information below)*

If a valid payment card has been provided to Eaton Apothecary on this form, or by any means in the future, I hereby grant Eaton Apothecary the authority to charge the complete outstanding balance of this to such a card on a periodic basis until such time as I provide written revocation of such authority. If no valid payment card information available, or for any reason Eaton Apothecary is unable to process my payment through my payment card, I agree to pay my complete balance, as shown on the billing Statement every month.

Card Type

□ American Express □ Discover □ MasterCard □ Visa

Card #:

Card Holder's Name

Card Expiration Date	*Billing ZIP Code*

☐ **PAY BY CHECK**

I agree to pay my complete balance, as shown on the billing statement every month

Eaton Apothecary may impose a FINANCE CHARGE of 1.5 percent per month and a LATE PAYMENT FEE of $15.00 per month on any balance not paid within the grace period. To avoid a FINANCE CHARGE and LATE PAYMENT FEE, all payments must be received no later than the last day of the calendar month in which the statement is originally printed. Charge Account terms and conditions are subject to change at any time. Eaton Apothecary may, in its sole discretion, limit, suspend, revoke or charge privileges at any time.

Signature*:_____ **Date:**_____

***SIGNATURE IS REQUIRED ON ALL APPLICATIONS.**

In Case of Errors or Inquiries about Your Statement.

The Federal Truth In Lending Act requires prompt correction of billing mistakes.

If you think your Statement is incorrect, or if you need more information about a transaction on your Statement, write us on a separate sheet of paper from your Statement at the payment address shown on your Statement. To preserve your rights under law, be sure your letter reaches us within 60 days of the date on your Statement where the transaction first appeared.

In your letter, please provide the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Description of the error and explain, if you can, why you believe there is an error.
- If you need more information, describe the item you are unsure about.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the undisputed parts of your Statement. During this time, we cannot report you as delinquent or take any action to collect the amount you question.

We must acknowledge all letters advising us of possible mistakes within 30 days of receipt unless we are able to correct your Statement within 30 days. Within 90 days after receiving your letter, we must either correct the error or provide you with a written explanation as to why we believe the Statement is correct. Once we have explained the Statement, we have no further obligation to you, even if you still believe there is an error except as provided herein.

If it is determined that we have made a mistake on your Statement, you will not have to pay any finance charges incurred as a result of the affected transaction(s). However, if it is determined that we have not made an error, you will have to pay any and all finance charges incurred as a result of the affected transaction(s).

If our explanation does not satisfy you and you notify us within 10 days of receiving our explanation of your intention not to pay the disputed amount, we may report you to credit bureaus and other creditors and we may pursue regular collection procedures. However, we must also report that you do not believe you owe the money and we must alert you regarding the parties to whom we released such information. Once the matter is resolved, we must notify the same parties of the ultimate resolution.

If we do not follow these rules, we are not allowed to collect the first $50.00 of the disputed amount and any finance charges thereon even if the Statement is determined to be correct.

Required Disclosures

Annual percentage rate (APR) for purchases	19.56% (1.5% per month)
Grace period for repayment of purchases	Minimum 23 days
Method of computing the balance for purchases	Adjusted Balance
Annual Fee	None
Late Payment Fee	**$15.00**
Minimum finance charge	$0.50

Eaton Apothecary

MedsPlus

New Customer Enrollment Form

REQUIRED DOCUMENT 2 OF 2

Customer Information

Last Name	*First Name*	*Middle Initial*	*Date of Birth*
Street Address		*Apt./Unit #*	*Social Security Number*
City	*State* / *ZIP*	*Telephone*	☐ *Male* ☐ *Female*
Allergies to Medications		*Diagnosis*	

Assisted Living Information (if applicable)

Move In Date:	*Preferred Start Date for Medications:*
Moving from: ☐ Personal Residence ☐ Hospital:_____ ☐ Rehab:_____ ☐ Other:_____	*Will you receive assistance with your medication?* ☐ YES ☐ SAMM ☐ LMA ☐ NO Independent with medication

Health Care Provider Information

	Name	*City & State*	*Contact Info*
Primary Care			*Phone:*
			Fax:
Other	*Specialty:*		*Phone:*
			Fax:
Other	*Specialty:*		*Phone:*
			Fax:

Prescription Drug Insurance Coverage

Please attach a copy of prescription insurance card(s). If there is more than one coverage type, please attach on a separate sheet.

Insurer Name	*Relationship to Policyholder*	*Person Code/Suffix (if applicable)*	
ID Number	*Rx Group*	*RxBIN (if listed)*	*RxPCN (if listed)*

Medicare Information

Medicare ID Number

Family/Caregiver Contact Information

	Name	*Relation*	*Contact Info*
Billing Contact			*Phone:*
			Email:
Health Care Contact			*Phone:*
			Email:

Previous Pharmacy

Name	*Phone #*

Authorization

By signing below, I authorize enrollment in the MedsPlus medication management program. I understand that I may cancel membership in MedsPlus at any time by providing written notice to Eaton Apothecary. As a member of MedsPlus, I agree to pay the monthly membership fee that will be included on my monthly billing statement ($24 as of 1/2015). I understand that the Medicine-On-Time® packaging system is not a child proof system and I accept full responsibility for keeping these medication packages in a safe place away from children or other people not intended to take them. Lastly, I acknowledge receipt of Eaton Apothecary's Notice of Privacy Practices and understand I may access the Notice at www.eatonapothecary.com/privacy.

*Signature of Patient or Patient's Personal Representative:*_____

23 Maple Street, Milford, MA 01757 • (p) 774.462.3200 • (f) 508.473.2490

Eaton Apothecary

MedsPlus

New Customer Enrollment Form

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(p) 774.462.3200 • (f) 508.473.2490

Patient Information

Last Name	*First Name*	*Middle Initial*	*Date of Birth*

Allergies to Medications

Medication List *

Medication	*Strength*	*Directions*	*Dosing Times*

ACCORDING TO STATE LAW, ALL PRESCRIPTIONS WILL BE FILLED GENERICALLY UNLESS "NO SUBSTITUTION" IS INDICATED

MD Signature:_____ **Refillable until:**_____

REFILLS WILL BE GOOD FOR ONE YEAR UNLESS OTHERWISE INDICATED

*** If more space is required, please attach an additional sheet of paper with remaining information**

Please provide written prescriptions for all CII-CV medications to pharmacy.