FAX OR ESCRIPT ALL PRESCRIPTIONS TO

# PRXP OF KS

300-340 Southwest Blvd, Suite 103|Kansas City, KS 66103

## Telephone: 913-233-4973 Fax: 913-233-4975

Clinic Name: 340B Eligible: ☐ Yes ☐ No

Today's Date: PCP: _____

| PATIENT INFORMATION (REQUIRED INFORMATION) | | | |
|---|---|---|---|
| **Patient's Last Name:** **First:** **Middle:** | | Sex: (Check One) ❑ Male ❑ Female | Birth Date: / / |
| Street Address: | Gender Identity: ☐ Male ☐ Female ☐ Transgender Other: | Home Telephone Number: | |
| P.O. Box: | City, State, Zip: | Emergency Contact Name | Emergency Contact Phone Number |

| CURRENT PHARMACY INFORMATION | | |
|---|---|---|
| Pharmacy Name | Telephone Number ( ) | Fax Number ( ) |
| Street Address | City, State | ZIP Code |

| INSURANCE INFORMATION (ATTACH FRONT AND BACK OF INSURANCE CARD) | | | | |
|---|---|---|---|---|
| Policy Insurance | | PCN | BIN | |
| Subscriber's Name | Group Number | | Patient ID | |
| Patient Relationship to Subscriber (Check One) | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |

| DELIVERY INFORMATION (CHECK ONE) | | |
|---|---|---|
| ☐ Patient's Address | ☐ Prescriber's Address | ☐ Other (Print Clearly) Street Address City, State, Zip |

## ACKNOWLEDGEMENT FORM
**(PLEASE SIGN)**

***BY SIGNING BELOW, I AUTHORIZE PRXP OF KS PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.***

***BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRATICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM.***

_____ _____

*Patient/Guardian Signature* *Date*

**Licensed in KS and MO*