SCANA Pharmacy LiveWell

Pharmacy – Patient Information Sheet

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Employee Name (if not employee): _____

Home Mailing Address: _____

City: _____ State: _____ Zip: _____

Patient Date of Birth: _____ Gender: ❑ **Male** ❑ **Female**

Phone numbers: **Home** _____ **Work** _____ **Cell** _____

Mail Code: _____ Employee ID: _____

ALLERGIES

Does the patient have any **drug, food, or other allergies**? If so, please list *(example: penicillin, peanuts)*:

❑ No known allergies

❑ Patient is allergic to: _____

DELIVERY

How do you want to receive your prescriptions?

❑ Pick up at the SCANA Pharmacy

❑ Mail them through Intercompany Mail

**I have read and agree to the terms of the Intercompany Mail Acknowledgement. Type your name to "sign".*

Signature: _____

PAYMENT

❑ Debit/ Credit Card (Flexible Spending Account/ Health Savings Account)

Please call the SCANA Pharmacy at 803-217-9173 to provide credit/debit card information.

❑ Payroll Deduction

**By signing below, I authorize SCANA Corporation to initiate a deduction for each medication order for both myself and my dependents from the SCANA Pharmacy. I have read and agree to the terms of the Payroll Deduction. Type your name to "sign".*

Employee signature: _____

CHILD RESISTANT CAPS

Do you prefer easy open caps? ❑ **YES** ❑ **NO**

(If you have small children in your home, please check no to receive child resistant caps.)

INSURANCE

BCBS ID: _____

Relationship to Employee: ❑ **Employee** ❑ **Spouse** ❑ **Dependent** ❑ **Retiree**

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of SCANA Notice of Privacy Practices. *(required – type your name to "sign")*

Patient Signature: _____ Date: _____

Signature of Parent or Guardian if patient is under 18: _____ Date: _____

*SCANA Pharmacy will supply all medications in **child resistant caps** unless otherwise requested by the patient. We will always **substitute a generic medication** if one is available and permitted by your physician. You must notify us if you prefer brand name on certain medications. SCANA Pharmacy strives to excel in customer service and protect your privacy in accordance with HIPAA. If you have any questions please call **SCANA Pharmacy at 803- 217-9173 or toll free at 1-866-769-9039.***

Updated 05.18.16

Pressing SUBMIT constitutes my electronic signature acknowledging that I have read and agree to the terms of this document.

SUBMIT