BLANDCLINIC.COM

SERVING THE HEALTHCARE NEEDS OF SOUTHWESTERN VIRGINIA/WEST VIRGINIA

BEFORE FILLING OUT THE APPLICATION, PLEASE READ THIS LETTER ENTIRELY. *PLEASE *KEEP THIS LETTER* FOR YOUR REFERENCE!

Dear Patient:

Please be sure to fill out the application *completely* and initial and sign *all* areas on the patient contract or the forms will be returned to you. The medication assistance program offers chronic medicine to help those with or without prescription coverage who cannot afford to purchase their medication. We can only get certain medications through the program. For example: medications for DIABETES, HIGH BLOOD PRESSURE, CHOLESTEROL, and some ANTIDEPRESSANTS.

- **IF YOU HAVE RX COVERAGE NO PROOF OF INCOME IS REQUIRED!!GENERICS AVAILABLE CHEAPER THAN MOST INSURANCE COPAYS**
- **IF YOU DO NOTHAVE RX COVERAGE INCOME DOCUMENTATION IS REQUIRED!! 1040 TAX FORM PG 1 & 2, AND/OR SOCIAL SECURITY AWARD LETTER ARE THE ONLY FORMS OF INCOME THE MANUFACTURERS WILL ACCEPT!!**

The medication will be requested from the pharmaceutical company and will be delivered to our office. **If you do not notify us if it is delivered to your home, you will not receive any refills!!** You will need to come to the clinic to pick up the medication. The medication will **not** be mailed under any circumstances. If you are unable to have the medication picked up within **2 weeks** from the time we notify you, please call us... If you do not contact us we will assume you do not want the medicine and will put it out for samples and we will not order any other medication for you. If you have a dosage change it is **YOUR RESPONSIBILITY** to notify us. If you have any questions feel free to call us at (276) 688-0441 FAX (276)688-2621.

Thank you
Bland County Medical Clinic
BJ Dillow RPhT, MAP Coordinator
Regina Arnold, Pt Advocate

PATIENT COPY
"KEEP"

PATIENT CONTRACT FORM

I agree to abide by the following responsibilities and conditions of the program:
(BE SURE TO INITIAL AFTER EACH)

I agree to provide **proof of income** that is legitimate and current upon request and update documentation annually, or as needed by the representative of the medicine program. I authorize any agent of the program to verify the information I provide. This may be done through my bank, Social Security Administration, Veterans Administration, my employer, or any other source from which I receive income. I understand that not providing requested documentation would result in being removed from the program. _____ (initial)

I understand that this is **not a reimbursement program** and that I am solely responsible for any medications I have previously purchased and may need to purchase in the future. _____ (initial)

I agree to **follow the Chronic Care Protocols** established by BCMC (including appropriate labs, EKG and X-Ray) and have a physical exam by a Provider at the clinic every 3 to 6 months depending on my age and medical condition(s). Failure to show up for or to keep timely appointments will prohibit medication being ordered and or dispensed. _____ (initial)

Diabetics- every three months, non-diabetics every six months

I understand that there may be **delays in getting my medicine** and that should I run out of my medicine before it is delivered, I am solely responsible for obtaining my medications until they arrive. Additionally, should there be any medications that are unavailable through the program, I understand it is my responsibility to obtain those without reimbursement from the program. _____ (initial)

I agree to promptly notify the patient advocate upon any **changes in my income** or the income of any of those in the household, number of people in the household, address, phone or any changes in my medication. _____ (initial)

CONTINUED ON BACK

I understand that **inappropriate behavior** on Bland County Medical Clinic property and/or such behaviors directed to any staff member of the clinic or this program will result in immediate permanent dismissal from this program. This includes foul language, threats of any kind, verbal abuse and unsuitable conduct verbal or otherwise. We will not tolerate being treated with disrespectful spoken or physical actions and acting in such a way will result in charges being filed against you. _____ (initial)

Medications not picked up will be given out as samples and you will be removed from the program. If medication is delivered to my home I agree to let the patient advocate know as soon as I receive it; I understand that failure to do so will result in being removed from the program. _____ (initial)

I authorize any agent of the program to **review my medical chart** as necessary to be able to order correct medications. I also authorize the representative(s) to discuss my medical condition(s) and needs with my provider to ensure correct medications are ordered. _____ (initial)

My signature below authorizes the patient advocate of the program to **sign my name** on the necessary forms needed to order my medication. The purpose of this is to expedite the ordering process by eliminating the mailing of forms back and forth for signature. _____ (initial)

It is my responsibility to contact the patient advocate when there is a change in my medication, "dosage change or no longer taking or added"_____(initial)

Finally, I understand that neither this program nor the agents of it are in any way guaranteeing or promising medication to me. _____ (initial)

I have read (or have had them read to me) and understand the Medication Assistance Program Guidelines and agree to follow all of the above requirements for the duration of any assistance I receive from the medicine program. I have received a copy of these guidelines.

_____ _____

Patient SIGNATURE and DATE PRINTED Name

MEDICATION ASSISTANCE PROGRAM
BLAND COUNTY MEDICAL CLINIC

1. YOUR HEALTHCARE PROVIDER IS: (circle one- this is *required*)

Dr. Michael Crews, DO Dr. LaDonna Bowling, DO Michelle McCarty, FNP

Jessica Terry, FNP Elaine Harper, ANP Donna Cruey, FNP Carolyn King, FNP

Debbie Croy, DNP, ANP Mary Jo Collie, DNP, FNP Nancy Davidson, DNP, FNP

OTHER: _____

2. PERSONAL INFORMATION:

YOUR NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ PHONE: _____

GENDER: (circle) Male Female BIRTH DATE: _____

MARITAL STATUS: _____ SOCIAL SECURITY NUMBER: _____

RACE (optional): _____ TOTAL IN HOUSEHOLD: _____ (including yourself)

We must have a copy of your driver's license or photo ID.

Do you receive any services from Mt. Rogers? ___yes____no

3. INCOME:

- **IF YOU HAVE RX COVERAGE NO INCOME DOCUMENTATION IS REQUIRED!!!!!**
- **IF YOU DO NOT HAVE RX COVERAGE, INCOME DOCUMENTATION IS REQUIRED!!! WE WILL ACCEPT LAST YEARS 1040 TAX FORM AND SOCIAL SECURITY AWARD LETTERS. ANY OTHER HOUSEHOLD INCOME MUST BE TURNED IN ALSO.**

_____SIGNATURE_____DATE

4. INSURANCE COVERAGE:

(YOU MUST CIRCLE ONE)

Medicare	Medicare supplement	Employer -provided
Medicaid	Veteran Benefits	None-Uninsured

Other (please specify): _____

5. DRUG ALLERGIES:

(PLEASE LIST ANY DRUG ALLERGIES YOU MAY HAVE, IF NONE PLEASE WRITE "NONE")

_____

6. CURRENT MEDICATIONS:

Name of drug	Dosage/Strength	Who Prescribed This Medication?

1. _____
2. _____
3. _____
4. _____
5. _____

7. PLEASE READ AND SIGN BELOW:

I certify by my signature below, that the information I have provided is true and correct and that the agent of the Medication Assistance Program can verify the above information using the necessary means.

The following people are authorized by me to pick up my medications:

_____ _____

_____ _____

_____ _____

Signature_____

Date: _____

MEDICATION ASSISTANCE PROGRAM
THROUGH THE BLAND COUNTY MEDICAL CLINIC

PATIENT CONTRACT FORM

I agree to abide by the following responsibilities and conditions of the program:
(BE SURE TO INITIAL AFTER EACH)

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Continued on back

INITIAL ALL _____ (initial)

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