Bernie's Pharmacy

Cash Discount Card
Patient Enrollment Form

Thank you for choosing Bernie's Pharmacy Cash Discount Card for prescription. We appreciate the opportunity to serve you. Bernie's Pharmacy Cash Discount Card offers you and your family discounted healthcare services for prescriptions.

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Patient Required Information

Please Print

Last Name: _____ First Name: _____ Middle Int.: _____

Address: _____ City: _____ State:_____ Zip: _____

Date of Birth: _____ Patient ID# Number: _____

[Leave Blank store will assign ID Number]

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: By accepting enrollment in the **Bernie's Pharmacy Cash Discount Card,** I hereby authorize, on behalf of myself, that **Bernie's Pharmacy** or its designated agent shall have access to any and all records pertaining to medical and pharmaceutical services rendered or treatment given to anyone enrolled or added to this application by any physician, health practitioner, hospital, clinic, or other medical facility for the purpose of review, investigation, or evaluation of a application or claim, documentation of pharmaceutical dispensing and usage, and for the purpose of analysis to develop more efficient pharmaceutical health care management. This release of information is to be made exclusively for the **Bernie's Pharmacy** and its designated agents.

[***Exclusions to the drug plan: Injectables, compounded prescriptions, and over-the-counter medications. Insulin and Imitre3.4saitr covtr***

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Pharmacy: Retain this form for your records and audits