Campers Pharmacy/Valley Pharmacy
CAMP MEDICATION THERAPY MANAGEMENT

Camp Name : _____

Parent Registration Form

Please complete and fax this form 973-584-7266 or scan and email to info@campers pharmacy.com

Please mail the prescriptions and/or manual form to the following address:

Valley Pharmacy, 107 Route 10 East, Succasunna, NJ 07876, PH: (973) 584-5555 or (973) 302-8568 Fax: 973-584-7266

Registration Number : **(For office Use only)**

Camper First Name		**Camper Last Name**	
Date of Birth		**Session Start Date**	
Gender		**Session End Date**	
Registration Deadline			

If more than one child is attending camp, please complete a separate form for each camper.

Parent/Guardian Information

Parent / Guardian Name	
Street Address	
City	
State / Zipcode	
Email	
Primary Phone Number	
Secondary Phone Number	
Cell Phone Number	

Please list any allergies or other information we should know regarding this camper.

Drug Allergies	
Other Allergies	
Special Instructions	

Medication Listing

Please list all medications (prescription or OTC) that the camper is currently prescribed. We understand that this list might change as we approach camp season.

Medication Name	Dosage	Medication Form	Medication Type(Brand / Generic)	Times of Administration	Directions
Ex:Ibuprofen	200mg	Tablet	Generic	Breakfast	1 Tablet daily

Note : Please indicate time of administration for each medicine.

Parent/Guardian Payment Authorization Form

Name on Credit Card	
Billing Street Address	
Billing City/State/Zip :	
Type of Card :	
Card Number :	
Expiration Date :	
Security Code :	

I acknowledge and assume responsibility and grant authorization for Valley Pharmacy and/or its parent company or affiliates to charge the above credit card for registration and sign-up fees where applicable. I also acknowledge responsibility for the cost of any medication not covered by my insurance company, for any medication that Valley Pharmacy cannot get reimbursement for, as well as any co-insurance and deductibles and charges for OTC/Sundries which I agree will be billed to my credit card by Valley Pharmacy.

I authorize Valley Pharmacy to contact my insurance company for verification of coverage, billing, and collections for my medications. As per our HIPAA agreement, all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection.

_____

Parent/Guardian Signature

Parent/Guardian Insurance Details

Parent/Guardian Insurance Information

Send a copy of both sides of the Parent/Guardian and Camper PRESCRIPTION Insurance card at the same time.

Insured Name			
Insurance Company Address/City/State/Zip			
Insurance Phone No			
Plan Name			
Type of Insurance (Primary/Secondary)			
Member Id		**Bin Number :**	
Group Number :		**PCN Number :**	

Physician Letter

Parents - complete this page and provide it to your child's Doctor.

Note: A separate form is needed for each camper.

Camper's Name : _____

Camp Session (please select one)

Select	Session Name	Start Date	End Date
[ ]			
[ ]			
[ ]			
[ ]			
[ ]			

Dear Healthcare Provider,

Your patient is attending a camp that employs a Medication Therapy Management System. All medication in pill form will be dispensed in dose packaging (unit or multi dose, depending on state law). The packages are labeled with name, date, dose, administration time, etc. The pre-packaged medication will be sent directly from our pharmacy to the camp.

Please note the following prescription guidelines:

1. **Please write a prescription for all medications including OTCs, vitamins, and supplements, a 30-day supply with enough refills to cover the entire camp stay.**
2. **Controlled Substance (Schedule III-V): Please write one prescription for each 30-day supply that is needed, with enough refills to cover the entire camp stay. The DEA requires all prescriptions to be dated and signed on the date issued.**
3. **Controlled Substance (Schedule II): Please provide one prescription for each 30-day supply sequentially. Do not postdate the prescription. The body of the prescription must provide written acknowledgement that indicates the earliest date that the pharmacy may fill.**

   For example: a prescription dated for 05/15/2017 for drug X should say "Do Not Fill Before 06/15/2017". (Do Not Fill Before date should be 2 weeks prior to session start date)
4. **Please include NPI number and DEA number on all prescriptions.**
5. **You may submit the prescriptions for your patient using one of the following methods:**

E-PRESCRIBING

Pharmacy Identifier	**Valley Pharmacy NABP 3115474 NPI 1083644819**

MAIL

Mailing Address	**107 Route 10 East Succasunna, NJ 07876**

FAX

Fax Number	**973-288-2060 Faxed prescriptions MUST come from healthcare provider's office. They may NOT be faxed by the parent/ guardian.**

VERBAL

Phone Number	**844-232-9472 973-512-2949**

IMPORTANT

Schedule II controlled substances MUST be e-prescribed or

written on an original prescription blank and mailed to our pharmacy

(e.g. Addreall, Concerta, Ritalin, Vyvanse). They may NOT be faxed.

Thank you for your help in making this a smooth and fun camp season for your patient! Please call us with any questions at (973) 512-2949 or email us at info@campers pharmacy.com

Sincerely,

Valley Pharmacy

VALLEY PHARMACY
107 Route 10 East
Succasunna, NJ 07876
Email : info@campers pharmacy.com
Tel :973-512-2949
Fax : 973-288-2060

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY.

LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

USE AND DISCLOSURES OF HEALTH INFORMATION

We are permitted, by law, to use and disclose health information about you for reasons concerning treatment, payment and healthcare operations. Examples: Treatment: We may disclose your health information to obtain payment for services that we provide you.

Payment: We may use and disclose your health information to obtain payment for service that we provide you.

Operations: We may use and disclose your health information in connection with our healthcare operations, which include administration and planning and other tasks that help us improve that quality.

Family and Friends: We may disclose your health information to a family member, relative or a friend that has been identified by you while you are present. If you are not present, professional judgement will be utilized to determine whether a disclosure is required or in your best interest. We will only disclose information that is beleived to be relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your health information in order to notify such persons of your location, general condition or death.

Requirements of the Law: We may use or disclose your health information when we are required to do so by Law.

Victim of Abuse or Neglect: We may disclose your health information to authorities if reasonable belief is that you are a possible victim of abuse, neglect or domestic violence. We may disclose information to the extent necessary to avert additional serious threat to your health or safety or the health or safety of others.

Public Health Activities: We may disclose your health information to public health authorities for the purpose of preventing or controlling disease or preventing injury; to alert a person who may have been exposed to a communicable disease; to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; to report information to a health oversight agency that is responsible for ensuring compliance with governmental rules and regulation, such as Medicare and Medicaid.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence and other national security activities.
Appointment Reminders: We may contact you to provide you with appointment reminders, such as voice messages; including essential information such as time, location and the name of the company/provider.

Worker's Compensation: We may use or disclose your health information to the extent necessary to comply with state laws relating to workers' compensation.

Disclosures Requiring your Authorization: For any reasons other than those listed in this notice, we may only use or disclose your health information with your written autorization. Your authorization must also be obtained prior to using your health information for any marketing activity.

YOUR RIGHTS TO YOUR PERSONAL HEALTH INFORMATION

Access to Record: You may have access to your health information, with limited exceptions. Request must be made in writing, utilizing our Record Access Request Form. We may charge a reasonable fee to compensate for time and materials.

Revocation of your Authorization: you may revoke your authorization to disclose your health information at any time. Request must be made in writing, using our Authorization Revocation form.

Restriction of Information: You may request that we place restrictions on our use or disclosure of your health information. You must make your request in writing by sending a letter that specifies the type of information to be restricted and to whom the information is to be restricted from. Request should be sent directly to the address listed in the heading of this Notice. We will consider all requests; however are not required to agree to the request. We will respond to all such requests in writing.

Disclosure Accounting: You may request a list of instances in which we (or our business associates) disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6years, but not before April 14, 2003. You must make your request in writing by sending us a letter that specifies the type of information and the time period involved. Requests should be sent directly to the address listed in the heading of this Notice. if you request this information more than once in a 12-month period, we may charge you a reasonable fee to compensate for our time and materials.

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing by sending a letter that specifies the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you have requested. Requests should be sent directly to the addess listed in the header of this Notice.

Amendment: You have the right to request that we amend your health information. You must make your request in writing by sending us a letter that explains why the information should be amended. Requests should be sent directly to the address listed in the header of this Notice. We will comply with your request unless we believe that the information to be amended is accurate and complete.

Right to Receive Paper Copy of this Notice: Upon request, you may obtain a paper copy of this notice.

QUESTIONS OR COMPLAINTS

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we have made about a request for access to your health information, a request you have made to amend or restrict the use or disclosure of your health information or a request you have made for us to communincate with you by alternative means or locations, you may complain to us using the contact information listed in the header of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.

If you have any questions, concerns or complaints about this Notice, please contact us.

I acknowledge that I have read and understand the following.

1. The registration fee is non-refundable.
2. A late fee of $30.00 will be charged if registered after the registration deadline.
3. All Controlled Drug Prescriptions should be written out for up to 30 days supply ONLY. If your child is attending camp for more than 30 days, a separate prescription is required for each 30 day period.
4. DO NOT FILL BEFORE date on controlled drug prescriptions should be 2 weeks prior to start of session.
5. All OTC'S require a prescription written by the physician.
6. All prescriptions should be written for the time of day the medicine is to be administered to the camper (i.e. breakfast, lunch, dinner, bedtime).If the medicine is taken as needed please make sure it is specified on the prescription.
7. All prescriptions will be filled generically (if available) unless otherwise specified by your physician as Do Not Substitute.
8. All prescriptions should be received by the pharmacy 3 weeks prior to start of session or late fee of $30.00 will be charged.
9. Please make sure that you send a copy of Prescription Insurance Card or the processing of prescriptions will be delayed.
10. I have received a copy of Valley Pharmacy's HIPPA policies.

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Parent/Guardian Signature