**Cornerstone Health Solutions**
41 Teed Dr.
Randolph, MA 02118
**Toll-Free:** (844) 319-7588
**Fax:** (781) 805-8221
**Email**: cornerstonemailorderpharmacy@bmc.org

**Hours of Operation:**
Weekdays - 7:00 am to 6:00pm
Weekends – Closed

**Webpage:**
**Cornerstonehealthsolutions.org**

# Delivery Service Enrollment Form

## Pharmacy Services

Thank you for choosing Cornerstone Health Solutions for your pharmacy services. We are happy to provide the delivery of your prescriptions at no shipping cost to you. To have your prescriptions filled, billed, and shipped to your address of choice please fill out the form below and fax or mail to Cornerstone Health Solutions. A pharmacy coordinator will contact you to confirm enrollment.

## Patient Information

| | | | |
|---|---|---|---|
| Last Name | First Name | Middle Initial | Date of Birth |
| Street Address | City | State | Zip Code |
| Apt No. / Telephone | | Cellphone | Gender ☐ Male ☐ Female |
| Email | Payment Methods: (Select from one of our available payment methods below) ☐ Visa ☐MasterCard ☐Discover ☐Amex ☐Other Credit | | |
| Drug Allergies: ☐No Known Allergies ☐Known Allergies _____ | | | |

## Designation of Personal Representative

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time.

I, _____ (First Name, Last Name) ,born _____ (MM DD YYYY) , hereby authorize my _____ (Relationship) , _____ (Representative First Name, Last Name)

of , _____ (Street Address) , _____ (City, State, Zip) To act as my personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me in the following form:

☐ All privileges that would be given to me with respect to my protected health information

**OR**

☐ Only for the following functions: _____

I understand that I may cancel this designation at any time by contacting Cornerstone Health Solution in writing or by phone. I understand any cancellation will be applied to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Printed Name: _____ Date: _____

Signature: _____

## Special Handling

| | |
|---|---|
| _____ | Please initial this line if you do not want child-proof caps mailed to your household. Snap caps or easy-off lids will be Sent with your medication if this line is initiated |

## Acknowledgment

Boston Medical Center Outpatient Pharmacy is required by law to fill your order with an FDA approved generic equivalent unless otherwise indicated by your provider. FDA approved generics contain the same active ingredient and come in the same dose form as their brand name counterparts.

Your prescription order will be delivered via U.S. Postal Services. Items may be shipped through other shipping methods on occasions. To maintain the integrity of the contents items including but not limited to the following will require signature: controlled substances, refrigerated items and Medicare covered products

Your selected payment method will be the default payment used to pay for each pharmacy order. Charge dates and amount will vary based on orders

All shipments are subject to federal, state and municipal pharmacy regulations.

## Consent

**By signing below, I acknowledge the above information to be accurate. I also assume responsibility for notifying Cornerstone Health Solutions of all medications that are no longer taken and/or have been discontinued by the doctor. If you are a parent/guardian of this patient, please sign your name below.**

## Signature

Date: _____

Patient Name: _____ Patient Signature: _____

Guardian Name: _____ Guardian Signature: _____