Patient/Third Party Signature Claim Log

Patient, Guardian or Legal Representative: Your signature certifies you received a service or item dispensed on the date(s) listed below and that the information contained hereon is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication identified and authorize release of all of the information contained on this log and prescription to which it corresponds, to the plan administrator, the underwriter, the sponsor, the policyholder, the Worker's Compensation Commission (if Applicable), and the employer. You hereby assign to this provider pharmacy any payment due pursuant to this transaction and authorize payment directly to this provider pharmacy.

Medicaid Patient/Recipients: Your signature certifies that you understand that payment for this service or item will be from Federal and State funds and that any false claims, statements or documents, or concertment of material may be prosecuted under applicable Federal and State Laws. Furthermore, as required by State Laws you acknowledge receipt of an *Offer To Counsel* and have accepted or refused counseling as indicated.

Workers Comp Claim: Your signature certifies that this medication is for the treatment of an on-the-job injury.

Plan/Third Party Program: Your signature certifies that any payment due pursuant to this transaction will be made directly to this provider pharmacy by the Plan/Third Party Program.

Acknowledgement of Receipt of HIPAA Privacy Statement: The undersigned acknowledges that they have been provided a copy of the HIPAA Privacy Statement. If the undersigned is not the patient, the undersigned certifies that they have the consent of the patient to receive health information, and they will provide the copy of the HIPAA Privacy Statement and acknowledgement of receipt to the patient to be returned to the pharmacy.

Date Received	Prescription Number(s)	Signature of Patient, Guardian, or Legal Representative. Acknowledges you have read and agree to the statements above and receipt of the HIPAA Privacy Statement.	Coverage through (Plan/Third Party)	Child Proof Container Yes/No	Workers Comp Claim Yes/No	Patient Counseling A = Accepted R = Refused

Date Received	Prescription Number(s)	Signature of Patient, Guardian, or Legal Representative. Acknowledges you have read and agree to the statements above and receipt of the HIPAA Privacy Statement.	Coverage through (Plan/Third Party)	Child Proof Container Yes/No	Workers Comp Claim Yes/No	Patient Counseling A = Accepted R = Refused