

Email Address: *

First Name: *

Middle Name: *

Last Name: *

Date of Birth: *

How did you hear about us? *

Delivery Address: *

Delivery City: *

Delivery State: *

Delivery Zip Code: *

Home Phone: *

Cell Phone:

Cell Carrier:

By checking this box, I authorize my protected health information to be released or shared with: _____

By checking this box, I authorize NPS Pharmacy to send me text messages.

By checking this box, I agree to pay NPS Pharmacy for all services rendered. This includes deductibles, co-pay amounts and non-covered items as determined by my insurance plan.

By checking this box, I acknowledge that I have received a copy of the Pharmacy's Notice of Privacy Practices. HIPPA Notice of Privacy Practices

By checking this box, I give NPS Pharmacy and FedEx, UPS, US Mail, or a NPS delivery driver my permission to leave my medication at my residence if I am unavailable to sign for it. I understand that by having my medication left at my residence, I am fully responsible for my medication and will not hold NPS Pharmacy responsible for any tampered medication. (If you always want to sign for your medication, please do not check this box.)

Please choose:

I prefer Safety Closure Caps on all bottles.

I prefer Non-Safety Caps (not child-resistant) By checking this box you SPECIFICALLY AGREE AND ACKNOWLEDGE THAT YOU RELEASE NPS PHARMACY AND ITS PHARMACISTS FROM ANY AND ALL CIVIL LIABILITY FOR NOT USING THE SAFETY CLOSURE CONTAINER.

Special Instructions:

List all allergies: _____, or

No known allergies (check the box if no allergies)

If you do not have Outlook please follow the directions below to submit the form:

- 1) Save Form
- 2) Email as an attachment to info@npspharmacy.com