* Required

Email Address: *

First Name: *

Middle Name: *

Last Name: *

Date of Birth: January 01 2016 *

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 understand that all medications sent to my residence will require a signature upon delivery.

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 ACKNOWL-EDGE 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

SUBMIT