

FRESNO

7130 N. Millbrook Ave
Fresno, CA 93720

Main Line:
559-326-1222

New Patient Department:
559-326-1905

Fax:
559-326-1228

California Cancer Associates for Research and Excellence (cCARE) is the largest full-service, private oncology and hematology practice in California.

With offices in the Southern California and Greater Fresno Area, cCARE offers extensive services and world-class care for every step of your treatment including: oncology, chemotherapy, radiation oncology, hematology, infusion and imaging.

At cCARE we believe that treatment is more than just medicine. It's about compassion, prevention, research and wellness. We know that cancer treatment requires medical intervention, but it is also our belief that a strong will and a solid support group will play vital roles in the healing process. That is why our expert team of board-certified hematologists, nurses and other highly-skilled cancer care professionals all work together closely with our patients and their loved ones throughout the course of recovery. It is this compassionate approach, combined with our state-of-the-art facilities, comfortable environment and commitment to utilizing the most advanced treatment techniques available that help make cCARE California's premier oncology center.

For your first visit, please complete and sign all forms. You will need to present these forms to the front desk when they are complete.

YOUR FIRST VISIT

To evaluate your health, it is extremely important that we receive your medical records prior to the time of your scheduled visit. Please arrange to have your doctor send these to our office before your initial appointment. To provide you the highest quality of care, your physician will need to review any pathology, surgical reports, x-ray scans, laboratory results, medical notes and in-patient records that are available.

We accept most insurance carriers and our staff will work with you before you come for your initial appointment to ensure that you have the coverage you will need. If you have a managed care plan that requires a referral from your primary care physician, please ensure that you have obtained that referral as it is the patient's responsibility to do so. Referrals occasionally have limits on the number of visits which patients may be allowed and/or an expiration date. Please monitor this information and obtain updated referrals as required. Co-payments, deductibles and non-insurance covered medical services are due at the time of the service.

WE ASK THAT PATIENTS ALWAYS:

- Bring insurance cards to each visit. If there is a secondary insurance plan, a Medicare supplemental plan, or a prescription plan, please make sure that we have all information. Please make sure to bring all your cards.
- Keep us informed of any change to any vital statistics such as address, telephone number, employment status, marital status or insurance.
- Provide a current list of medications at each office visit; it is necessary that we review all prescription and over-the-counter medications currently taken. Please bring your prescription card. Some patients find it more convenient to bring the medication bottles to the appointment. Note that over the counter drugs include vitamins, herbs, aspirin, Tylenol, etc.
- Allow a 48-hour turnaround for prescription refills. Please note that some prescriptions for pain medications do not allow refills, therefore we request that patients contact us prior to running out of any medication.
- Consider the compromised immune systems of other patients, and refrain from bringing children to your appointments.
- Write down any questions or concerns that arise to discuss with the physician.

Once a patient has made an appointment, all facets of our services—from the latest research findings to the most advanced technology—will be utilized in providing the highest level of quality medical care. Please complete the patient registration forms BEFORE your appointment.

Again, we welcome you and say thank you for choosing our practice. For further information, please visit our website at cCARE.com and should you need additional assistance, please call:

- Fresno - New Patient Department: 559-326-1905

PLEASE PRINT CLEARLY

Today's Date: _____

Patient Name: _____

DOB: ___ / ___ / ___ Age: _____ Gender: Male Female Transgender: M to F F to M

SSN: _____ Cell Phone: (_____) _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ May we email you? Yes No

Preferred Language: _____

Ethnicity/Race: White Hispanic/Latino Black/African American Native American

Asian/Pacific Islander Other

Occupation: _____

Employed/Self Employed Unemployed Retired Disabled

Name of Employer: _____ Work Phone: (_____) _____

Relationship Status: Married Single Widowed Divorced Other

Living situation: Lives Alone Lives with Family Lives in Nursing Home

Winter Resident Year Round Resident

Are you currently receiving home health? Yes No

Children: Yes No If yes, how many? _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different): _____ Phone #: _____

List Any Other Physician: _____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Patient Initials: _____

PLEASE PRINT CLEARLY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone #: (____) _____

Durable Power of Attorney for Healthcare: Yes No _____

Relation to You: _____

Living Will for Healthcare: Yes* No *Please provide a copy for our records

PRIMARY

Insurance Carrier: _____

Name of Primary Policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's Employer: _____

Insurance ID #: _____ Group #: _____

Does plan have prescription coverage? Yes No (If yes, please provide information below)

Prescription Coverage: _____

SECONDARY

Insurance Carrier: _____

Name of Primary Policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's Employer: _____

Insurance ID #: _____ Group #: _____

Does plan have prescription coverage? Yes No (If yes, please provide information below)

Prescription Coverage: _____

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Patient Initials: _____

Witness Name: _____ Witness Relationship: _____

Witness Signature: _____

PLEASE PRINT CLEARLY

Patient Name: _____

Reason For This Visit: _____

SURGICAL HISTORY

Procedure	Date Performed	By Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have an implanted device, such as a pacemaker? Yes No

If yes, please provide a copy of your device card for our records.

Have you ever been diagnosed with cancer? Yes No

Have you had radiation or chemotherapy treatment in the past? Yes No

ALLERGIES AND SENSITIVITIES:

(List Allergies you have and how each affects you.)

No known allergies

No known drug allergies

Allergy

Reaction

_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a reaction to anesthetic? Yes No

CURRENT MEDICATIONS:

(ATTACH MEDICATION LIST IF NEEDED)

Name	Strength / Frequency	Prescriber
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL NON-PRESCRIPTION MEDICATION INCLUDING VITAMINS AND HERBS:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy _____ Address _____ Phone # _____

Patient Initials: _____

FAMILY MEDICAL HISTORY:

Indicate any family members with breast, ovarian, pancreatic, prostate, melanoma, colon, kidney or uterine cancer, blood disease or other disease.

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sisters/Brothers:	_____	_____	_____
Children:	_____	_____	_____
Aunts/Uncles:	_____	_____	_____
Maternal Grandparents:	_____	_____	_____
Paternal Grandparents:	_____	_____	_____

SOCIAL HISTORY:

Work Hazards:

Any occupational hazards (like noise or chemical exposures)? Yes No If yes, what: _____

Tobacco Use: (Present and/or past)

- Never smoked
- Quit smoking When? _____ How many years did you smoke? ___yr(s) Age started: _____
How many packs? _____/day
- Currently smoke Cigarettes Pipe Cigars Electronic cigarettes
How many packs? _____/day How many years? _____
- Chewing tobacco Current Past How long? _____

Alcohol Use: (Present and/or past)

- Non-drinker
- Beer: Number of bottles _____ per Day Week Month
- Wine: Number of bottles _____ per Day Week Month
- Liquor: Number of bottles _____ per Day Week Month

NUTRITIONAL HISTORY:

Has there been a change in your appetite in the past 6 months? Yes No

How is your appetite? Appetite Good Appetite Fair Appetite Poor

Have you gained or lost weight in 1 month without wanting to? Yes No

If yes, how much gain or loss? _____

Are you happy with your weight? Yes No

If not, are you on a diet and exercise program? Yes No

For women: Are you taking any extra calcium? Yes No

REVIEW OF SYSTEMS:

(Please check any past or current symptoms you have.)

General:

- Good Health
- Excessive Fatigue
- Weight Loss
- Obesity
- Unexplained Fevers
- Chills
- Weakness

Immune System:

- Frequent Colds
- Outdoor Allergies
- Serious Infections

Respiratory:

- Pneumonia
- Tuberculosis
- Emphysema
- Asthma
- Chronic Cough
- Productive Cough
- Coughing Up Blood
- Short of Breath
- Wheezing

Head and Neck:

- Cataracts
- Glaucoma
- Sinus Problems
- Sore Throat

HEENT:

- Blurred Vision
- Double Vision
- Glaucoma
- Sensitivity to Light
- Dry Eyes
- Excessive Tearing
- Hearing Loss
- Ringing in Ears
- Mouth Sores
- Dry Mouth
- Altered Taste
- Sinus Tenderness
- Hoarseness
- Jaundice

Endocrine:

- Diabetes
- Thyroid Disorder
- Hot Flashes
- Night Sweats
- Hormone Replacement

Hematological:

- Anemia
- Swollen Lymph Nodes
- Blood Clots
- Platelet Problems
- Surgical Bleeding
- Abnormal Bruising
- Bleeding Gums
- Nose Bleeds
- Blood Transfusions
- Bleeding Disorder
- HIV/AIDS

Breast:

- Abnormal Masses
- Nipple Discharge
- Nipple Inversion
- Pain
- Skin Changes
- Axillary Mass

Cardiovascular:

- Chest Pain
- Palpitations
- Heart Attacks
- Hypertension
- Heart Failure /
Heart Disease
- Leg / Feet Swelling
- Heart Murmur
- Rhythm Problems
- High Cholesterol
- High Blood Pressure
- Diabetes - Type 1 / Type 2

Gastrointestinal:

- Constipation
- Diarrhea
- Vomiting

- Stomach Ulcers
- Rectal Bleeding
- Gallbladder Problems
- Hepatitis
- Reflux Disease
- Black Stools
- Bowel Changes
- Abdominal Pain
- Hemorrhoids
- Nausea
- Kidney Stones
- Difficulty Swallowing
- Heartburn
- UTI
- Cirrhosis of Liver

Genitourinary:

- Urinary Loss
- Frequent Urination
- Pain with Urination
- Blood in Urine
- Bladder Problems
- Incontinence
- Hesitancy
- Erectile Problems

Musculoskeletal:

- Arthritis
- Bone Pain
- Gout
- Osteoporosis
- Muscle Pain
- Joint Pain
- Joint Swelling
- Limited Range of Motion
- Back pain

Neurological:

- Headache / Migraine
- Focal Weakness
- Paralysis
- Neuropathy
- Speech Impairment
- Tremor
- Altered Consciousness
- Balance / Dizziness

REVIEW OF SYSTEMS CONTINUED:

(Please check any CURRENT symptoms you have)

Neurological: (Continued)

- Stroke / TIA
- Seizure
- Fainting Spells
- Memory Loss
- Confusion

Psychiatric:

- Sleep Trouble
- Depression
- Anxiety
- Appetite Changes
- Suicidal Thoughts
- Panic Disorder

Integumentary (Skin):

- Rash
- Itching
- Skin Lesions

Gynecologic:

Heavy Periods: Yes No

Age Period Started: _____

Date of Last Period: _____

of Pregnancies: _____

Abortions / Miscarriages? Yes No

Breastfeed: Yes No

Date of Last Pap: _____

Date of Last Mammogram: _____

Have you ever had a colonoscopy? Yes No

Date of most recent: _____

Signature: _____ Date: _____

Patient Initials: _____

OTHER ILLNESS OR MEDICAL PROBLEMS:

(Please list current and past medical problems that you have been treated for AND the physician who treated you.)

Illness / Medical Problem

Physician

PAIN SCALE

Are you in pain? Yes No

If yes, please indicate on a scale of 1-10 (0= no pain, 10= worst pain)

1 2 3 4 5 6 7 8 9 10

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
TO cCARE AND ITS ASSOCIATES**

PATIENT INFORMATION: PLEASE PRINT CLEARLY

Patient Name: _____ SSN: _____

Telephone Number: _____ DOB: _____

INFORMATION TO BE RELEASED FROM/TO: FROM TO

I hereby authorize the release of information in my medical record from/to (Provider Name):

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

Including contents regarding drug or alcohol abuse, psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/pr test results. Exclusions to the above: _____

INFORMATION TO BE RELEASED FROM/TO: FROM TO

FRESNO
7130 N. Millbrook Ave
Fresno, CA 93720
P: 559-326-1206
F: 559-326-1233

TYPE OF RECORD:

- ALL MEDICAL RECORDS (pertinent only)
(limited 2 years of information)
- History & Physical
- Discharge Summary
- Operative Report
- Consultation Report

- Psychotherapy Notes Only
- Radiology Reports (Specify): _____
- Lab Results
- Evidentiary Examination
- ER Report
- Other Information (Specify): _____

PURPOSE OR NEED FOR THIS INFORMATION IS:

(Please check all that apply)

Medical Insurance Legal Personal Other: _____

PLEASE PRINT CLEARLY

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.

SIGNATURE:

_____ Date: _____
(Patient / Legal Representative / Guardian)

(PHYSICIAN PART ONLY)**Records obtained in the course of PSYCHIATRIC TREATMENT**

The undersigned, the physician, licensed psychologist or social worker with a master's degree in social work hereby (approves) (disapproves) the release of information and records. Please note below any restrictions on the release of records. (Note: No approval is required for release to the patient's attorney.)

If denied, please provide reason: _____

Signature: _____ Date: _____
(Physician / Psychologist / Social Worker)

FRESNO Medical Records: Phone: 559.326.1206 Fax: 559.326.1233



AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

PLEASE PRINT CLEARLY

Patient Name: _____ DOB: _____

Thank you for choosing cCARE as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to cCARE to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to cCARE.

CARE MANAGEMENT SERVICES

I give permission to cCARE to provide care management services as part of my overall medical services. Services include help with coordinating my cancer care between visits, accessing community resources, and understanding my treatment for cancer. I may withdraw my consent at any time by notifying the practice in writing.

USE OF PHOTOGRAPHY

I agree the any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-PRESCRIPTION FOR MEDICATION HISTORY

We may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize cCARE to release medical and other information to the necessary insurance companies and third party payers required for payment or rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to cCARE. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits form.

Signature of Patient or Guardian: _____ Date: _____



AUTHORIZATION TO RELEASE HEALTH INFORMATION & NOTICE OF PRIVACY PRACTICES

PLEASE PRINT CLEARLY

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

No, please do not discuss PHI with anyone. **WARNING:** If you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.

Yes, allow communication with:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

Medical Care Billing and Payment Information

I, _____, understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practices for cCARE.

Patient Signature Print Name Date

Date of Birth: _____

PRESCRIPTION REFILL POLICY

All cCARE providers (physician, nurse practitioner or physician assistant) participate in electronic prescribing directly to your local and mail order pharmacies. Our goal is to assist patients with prescription requests in an efficient and timely manner. In order to process your request as quickly as possible, please see the details of our prescription policy.

- Prescription refills require close monitoring by your physician, nurse practitioner or physician assistant to ensure the safe continuation of the appropriate dose, frequency and term of that medication. Your provider will prescribe the appropriate number of prescription refills to last you until your next scheduled appointment.
- It is the patient's responsibility to schedule their next appointment in advance and with adequate time to receive a prescription refill.
- Maintaining current pharmacy information is the responsibility of the patient. Please confirm with our practice that your correct local pharmacy address and phone number or mail order pharmacy information is on file. Prescription refill requests will be submitted electronically to your pharmacy. Your pharmacy will contact you when your prescription is ready.
- Prescriptions classified as controlled substances are not processed after hours or on the weekends.
- Please allow 48-72 hours to process prescription requests. Medications requiring pre-authorization may require additional time to process. Please plan ahead for refills during holidays and when traveling.
- Should you require an emergency refill, prescription refill requests should be electronically submitted from the pharmacy directly to the office. If approved by your provider, an appropriate refill will be submitted to your preferred pharmacy. If your prescription refill is not approved, please contact your provider's office to schedule an appointment.



LATE ARRIVAL POLICY AND ELECTRONIC COMMUNICATION POLICY

ELECTRONIC COMMUNICATIONS

For your convenience, our office communicates through different electronic means including our secure patient portal, phone and text messaging for appointment reminders.

May we contact you at:

Home? Yes No Number _____ Work? Yes No Number _____

Cell? Yes No Number _____

Via Email? Yes No Email Address _____

May we send appointment reminder via text? Yes No

May we leave a message on your answering machine or cell? Yes No

Any information? Yes No

Limit information to the following: _____

May we leave a message with a family member or other person at your home? Yes No

Any information? Yes No

Limit information to the following: _____

Please check below if you do NOT want to be contacted by cCARE in any of the following methods of communication:

Cell Phone Text Message Home Phone Secure Email Online Patient Portal

Is it okay to leave a detailed message on your voicemail? Yes No

Signature of Patient or Representative

Date

LATE ARRIVAL POLICY

Patients arriving more than 10 minutes late for a scheduled office visit or procedure appointment will be rescheduled for another day.

Dear Patient,

Thank you for choosing cCARE as your healthcare provider. We are committed to providing you with quality healthcare. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, if you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
 - a. **Non-contracted insurances.** If we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services.** Please be aware the some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before seeing the doctor. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our office immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice. (A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.)
8. **Missed appointment policy.** Our policy is to charge an assessment fee to patients who miss their appointment. For your convenience, cCARE accepts Checks and Credit Cards. We accept Visa, MasterCard, Discover and American Express. Fees: \$50.00 fee per missed office visits, \$100.00 fee for missed office procedure and \$200.00 fee for missed surgery.
9. **Financial Counselor.** We have a Financial Counselor available as a resource to our patients.
10. **California Open Payments Notice.** The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

Signature of Patient or Responsible Party

Date

Print Name

Relationship to Patient



PHYSICIAN OWNERSHIP DISCLOSURE NOTICE TO PATIENTS

PLEASE PRINT CLEARLY

Patient Name: _____

Thank you for choosing cCARE as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our ownership disclosure. If you would like to receive a more detailed explanation of our policies, please request a copy.

PHYSICIAN OWNERSHIP DISCLOSURE

Physician Financial Interest and Ownership: The PET/CT services provided in this center are owned by the physicians. The physician(s) who referred you to these ancillary services have a financial and ownership interest.

Patients have the right to have these services performed at another healthcare facility of their choice. We are making this disclosure in accordance with federal regulations. This notice is mandated by the Patient Protection and Affordable Care Act (PPACA) and follows rules promulgated by the Centers for Medicare and Medicaid Services (CMS).

PATIENT NOTIFICATION

ALTERNATIVE SUPPLIERS OF PET AND CT IMAGING (FRESNO)

California Imaging Institute | 1867 E. Fir Avenue, Suite #101 | 559-325-5800

Valley Metabolic Imaging | 6121 N. Thesta Street, Suite #207 | 559-449-2640

Advanced Medical Imaging | 6297 N. Fresno Street | 559-447-4000

Community Regional Medical Center | 2823 N. Fresno Street | 559-459-3984

St. Agnes Medical Center | 1313 E. Herndon Avenue | 559-450-3210

I (or patient's guardian, if minor) acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician and me, and understand the information outlined herein. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

Signature of Patient or Guardian: _____ Date: _____



cCARE DISPENSING

Our team is ready to promptly fill your medication or send it to your local pharmacy.

**STOP BY OUR CHECK-OUT COUNTER
TO FILL YOUR PRESCRIPTION TODAY!**

Quick Authorizations | Access to Grants



FOR ADDITIONAL
INFORMATION
PLEASE CALL

559-326-1219