

Parents of boarding students must complete the following forms. Please note that ALL medications will originate from the Health Complex Pharmacy. They will submit all claims to the insurance company and bill your credit card for co-pay amount. It is your responsibility to update all insurance changes immediately with Health Complex. It is Health Complex's intentions to bill all eligible prescriptions to your insurance company. However, in the event that Health Complex does not have the current insurance information for billing, they will charge your credit card for the normal and customary prescription charge.

**HEALTH COMPLEX PHARMACY  
CHARGE ACCOUNT APPLICATION**

Student name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Age \_\_\_ Sex \_\_\_

City/State/Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_

Student Medication Allergies \_\_\_\_\_

Custodial Parent: Father \_\_\_ Mother \_\_\_ Both \_\_\_ Other \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Res. Phone \_\_\_\_\_

Bus. Phone \_\_\_\_\_

Mother's Full Name \_\_\_\_\_ Res. Phone \_\_\_\_\_

Bus. Phone \_\_\_\_\_

Guardian's Full Name \_\_\_\_\_ Res. Phone \_\_\_\_\_

Bus. Phone \_\_\_\_\_

Name of Prescription Insurance Company \_\_\_\_\_ Phone# \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

*Please return this application to the Taft Student Health Center prior to your child's arrival to the school. It will be forwarded to the Health Complex Pharmacy. Be sure to attach a copy of your prescription plan card, both sides, enlarged, readable.*

**\*\*Expiration date must be valid for the entire year. If not listed or date expired, the pharmacy cannot process the charges.  
PLEASE NOTIFY US OF NEW CARD NUMBERS AND EXPIRATION DATES.**

Co-pay charges: A valid credit card and expiration date must be given.

(Circle one) Mastercard Visa American Express Discover

Card# \_\_\_\_\_ Expiration Date \_\_\_\_\_ V-Code \_\_\_\_\_

Name on Card \_\_\_\_\_ Billing Address \_\_\_\_\_

I hereby give my permission to charge the above credit card for the co-pay or normal and customary amount of my child's prescriptions.

Signed \_\_\_\_\_

Send changes of insurance coverage to:

Health Complex Pharmacy and Medical Supply, 35 Deforest Street, Watertown, CT 06795

Telephone # (860) 274-8816 Fax # (860) 945-1728