PHARMACY NAME

INSURANCE CLAIM LOG The undersigned certifies: that the person for whom the prescription was written is eligible for benefits; that they have received the prescription listed; that they authorize release of all information contained in this log, the prescription to which it corresponds and subsequent claim to parties concerned; that they are the person for whom this prescription is being obtained or are authorized to execute on behalf of such person; that this medication is not for an on-the-job injury or covered by other insurance plan; and that they assign payment for this transaction directly to this pharmacy.	***ACKNOWLEDGEMENT OF RECEIPT OF COPY OF THE NOTICE OF PRIVACY PRACTICES***

DATE	RX NUMBER	INSURANCE PROGRAM	Signature of Patient, Guardian or Legal Representative	COUNSELING REQUEST	**For New Patients:**
			______________________________ INITIAL FOR **NON-SAFETY** CAP___	☐ YES ☐ NO	**I acknowledge receipt of a copy of the Notice of Privacy Practices.** ☐ (please check)
			______________________________ INITIAL FOR **NON-SAFETY** CAP___	☐ YES ☐ NO	**I acknowledge receipt of a copy of the Notice of Privacy Practices.** ☐ (please check)
			______________________________ INITIAL FOR **NON-SAFETY** CAP___	☐ YES ☐ NO	**I acknowledge receipt of a copy of the Notice of Privacy Practices.** ☐ (please check)
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			______________________________ INITIAL FOR **NON-SAFETY** CAP___	☐ YES ☐ NO	**I acknowledge receipt of a copy of the Notice of Privacy Practices.** ☐ (please check)

I certify that the prescriptions referred to hereon were lawfully dispensed to the person whose signature appears above and the prescriptions comply with the conditions and applicable instructions of the third party program identified. I also certify that the information covering each transaction is, to the best of my knowledge, correct and that all documentation is available for audit.

PHARMACIST SIGNATURE____