23679 Calabasas Rd. #800
Calabasas, CA 91302

PERSONAL INJURY PHARMACY CARD

Fax completed form to (800) 921-4811
(Call 866-757-1545 to expedite processing)

Card can be faxed or emailed directly to attorney

Client Information:

NAME: ______________________ DATE OF BIRTH: ____________

ADDRESS: ______________________ PHONE #: ____________

______________________ SSN: ____________

GENDER: DATE OF INJURY: ____________ CARD EXPIRATION: ____________

Attorney Information:

NAME: ______________________

FIRM NAME: ______________________

PHONE #: ______________________

FAX #: ______________________

ADDRESS: ______________________

____

CONTACT: ______________________

EMAIL: ______________________

Doctor Information:

NAME: ______________________

PHONE #: ______________________

FAX #: ______________________

Pharmacy Information: (OPTIONAL)

NAME: ______________________

PHONE #: ______________________

FAX #: ______________________

I do hereby authorize Buena Vista to furnish you, my attorney, with a full report and/or billing statement outlining, the prescription medication and other products provided by Buena Vista, relating to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Buena Vista Pharmacy, Inc. such sums as may be due and owing for pharmacy service rendered to me by reasons of the accident and any other bills that are due said pharmacy, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said pharmacy. And I hereby further give a lien on my case to said pharmacy against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection there with.

I fully understand that I am directly and fully responsible to said pharmacy for all medication and supplies provided to me and that this agreement is made solely for said pharmacy's additional protection in consideration of said pharmacy awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fees. If this account is assigned for collection and/or suit, collection costs and/or attorneys fees, and/or court costs will be added to the total amount due.

Drug Name	QTY

Patient Signature: ______________________ **Date:** ____________

The undersign being attorney of record for the above patient does hereby agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said pharmacy above named.

Attorney Signature: ______________________ **Date:** ____________

FAX COMPLETED ACTIVATION FORM TO (800) 921-4811
OR EMAIL TO ACTIVATE@BUENAVISTARX.COM