

**PAR Controlled Medication**

**Pharmacy Refills**

\*\* Please be aware that some pharmacies are not certified to accept controlled prescriptions. When you are requesting your refill please have the nurse or doctor confirm that your pharmacy has the ability to accept controlled prescriptions electronically.\*\*

Patient's Name:

DOB:

\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

By signing below I am agreeing to have my child's controlled medication faxed to an EPCS Pharmacy for a yearly fee of \$25.00. I understand that I still need to call P.A.R. each month to request this medication, that P.A.R. requires 48 hrs to refill medications, and that refills are not processed on Mondays or Holidays.

Non-refundable yearly fee of \$25.00 per child

Parent's Name : \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

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(OFFICE USE ONLY)

Acct Number: \_\_\_\_\_

Amount Paid: \_\_\_\_\_

Next Payment due: \_\_\_\_\_

\_\_\_\_\_ Front Desk (Chart Note/Scan)

\_\_\_\_\_ Billing Office