NEW YORK CARDIOLOGY ASSOCIATES P.C.

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PREFERRED/IN-NETWORK PHARMACY AND LABORATORY INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

PHARMACY

Our office offers Electronic Prescribing. We request that you list the pharmacy of your choice below. If you use a chain pharmacy, such as Duane Reade or CVS, please include the store number as well as the address and/or phone number. If you use a mail order pharmacy, please indicate which one below.

PHARMACY NAME:_____ **STORE#:** _____

ADDRESS:_____ **PHONE#:** _____

MAIL ORDER PHARMACY (Please check only one.)

- ☐ **EXPRESS SCRIPTS**
- ☐ **COSTCO MAIL ORDER**
- ☐ **CIGNA HOME DELIVERY**
- ☐ **RIGHTSOURCE Rx**
- ☐ **PRESCRIPTION SOLUTIONS**
- ☐ **AETNA Rx HOME DELIVERY**
- ☐ **CVS/CAREMARK MAIL ORDER**
- ☐ **CVS/CAREMARK SPECIALTY**
- ☐ **OTHER:** _____

LABORATORY SERVICES (Please check only one.)

Lab specimen collected in our office will be sent to Quest Diagnostics. However, certain insurance carriers only cover laboratory services at 100% through a preferred laboratory. If your insurance requires you to utilize a specific laboratory, please indicate below. We strongly urge you to call your insurance carrier before coming in for services to find out which laboratory companies are in-network for your plan.

- ☐ **LABCORP**
- ☐ **OTHER:** _____

ELECTRONIC HEALTH RECORD

As a component of Electronic Health Record, the government has determined that the following demographics should be included in your patient profile.

Preferred Language

- ☐ **ENGLISH**
- ☐ **GERMAN**
- ☐ **FRENCH**
- ☐ **SPANISH**
- ☐ **ITALIAN**
- ☐ **ARABIC**
- ☐ **CHINESE**
- ☐ **OTHER:** _____

Race

- ☐ **DECLINE**
- ☐ **ASIAN**
- ☐ **CAUCASIAN**
- ☐ **BLACK OR AFRICAN AMERICAN**
- ☐ **AMERICAN INDIAN/ALASKA NATIVE**
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**

Ethnicity (Please check only one)

- ☐ **DECLINE**
- ☐ **HISPANIC OR LATINO**
- ☐ **NOT HISPANIC OR LATINO**
- ☐ **OTHER/UNDETERMINED**

I attest that the pharmacy and laboratory information provided is true and accurate to the best of my ability. As a component of Electronic Prescribing, we need your consent to access your medication history from your pharmacies. Please sign your name below if you give your consent.

SIGNATURE: _____ **DATE:** _____

(NYCA Rx&Lab 2023)