Sierra Family Health Center

Caring for you as family

TERRY STROM
CHIEF EXECUTIVE OFFICER

PETER D. VAN HOUTEN M.D.
MEDICAL DIRECTOR

VICTORIA KNOLL
CHIEF FINANCIAL OFFICER

Welcome to Sierra Family Health Center. We're very happy that you have chosen us for your health care. Our mission is to provide comprehensive, compassionate, and quality medical, dental, and behavioral health care to everyone. We strive to be a center of healing, learning, and caring, and are committed to quality and to adding value in every aspect of our work. We are a nonprofit community health center with locations at:

On the San Juan Ridge
15301 Tyler Foote Road, Nevada City | 530.292.3478
Monday-Friday 8:30 a.m.to 5:00 p.m.
Saturdays 10 a.m. to 2 p.m.

In Oregon House
8676 Marysville Road| 530.692.9073
Monday, Tuesday and Thursday, 8:30 a.m. to 5:00 p.m.

We accept Medi-Cal, Medicare, most private/commercial insurance, and offer a sliding fee discount for those who qualify. Please see our Financial Policy Information sheet for more details.

If do not have insurance, please ask for a Patient Advocate to help you determine if there is insurance for which you might be eligible.

We ask that you arrive 15 minutes prior to your scheduled appointment to check in and address any needed paperwork.

Sierra Family is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. To notify us of any changes or cancellations, please call us at (530) 292-3478 as soon as you can, but no later than 2:00 p.m. on the day prior to your scheduled appointment. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

We look forward to you becoming part of Sierra Family!

Grateful Patient Testimonials

"I have been a patient for over 23 years, and the wonderful staff have been a blessing for me, especially in the last few years. I've been through some tough times, and they have been concerned about me, emotionally and medically."

"I always had bad experiences with dentists until coming here. You removed all my dental fears with your kind and gentle care."

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PATIENT REGISTRATION

Please provide us with your insurance card and valid ID

Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____Social Security#_____-_____-_____ Gender at Birth ◯Male ◯Female

Mailing Address_____City_____

State_____Zip Code_____Email Address_____

Physical Address (if different)_____

City_____State_____ZipCode_____

Telephone: Home _____ Cell _____ Work_____

Primary Phone: ◯ Home ◯ Cell ◯ Work Preferred Time of Call: ◯ Morning ◯ Afternoon ◯ Evening

Length of Message: ◯ Brief ◯ Extended On Which Phone? ◯ Home ◯ Cell ◯ Work

Preferred Language: ◯ English ◯ Other: _____ Interpreter needed? ____Yes ____No

Would you like access to your medical provider team and (limited) medical records online? ____Yes ____No

If yes, please see Your Patient Portal information sheet included in this packet.

Which pharmacy do you use (Please see our Preferred Pharmacy information)?

Pharmacy Name _____ City _____

Parent Information If Patient Is Under 18:

Parent/Legal Guardian _____Birthdate_____

Contact Phone_____Email:_____

Type of Parent(s) ____Biological _____Adoptive ____Foster ____ Other _____

Parent/Legal Guardian _____Birthdate_____

Contact Phone_____Email:_____

Type of Parent(s) ____Biological _____Adoptive ____Foster ____ Other _____

Emergency Contact:

Let us know who to call if there's an emergency. This person also needs to be listed on the HIPAA authorization form.

Name_____Relationship_____

Cell Phone_____Home_____

Financial and Insurance Information:

Here we need the details about the account holder (the person that will be paying for services).

☐ Medicare ☐ Medicare Supplemental _____

☐ Medi-Cal (type): _____

☐ Commercial (type):_____

☐ Self-Pay

Patients may be eligible to receive a discount through the sliding fee discount program. Discounts are based on family size and household income. Our staff can help you with questions regarding our health care and dental plans.

Account Holder or Person Paying:

Co-pays and outstanding balances are due at the time of service. Insurance is billed after the visit. Sometimes there is still money owed. Who should we send statements to?

_____Patient _____Other

If you marked Other, please let us know:

Last Name_____First Name_____Initial_____

Relationship to Patient_____

Address_____City _____

State_____ZipCode_____Email Address)_____

Cell Phone_____Home_____Work_____

Consent

In order to provide treatment, coordination of clinical care, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and by providing your signature below.

Consent for Treatment: I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself (or child/dependent stated above) while a patient at the Sierra Family Health Center. _____ (initials)

Consent for Release of Medication History: I give my permission to allow SFHC to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. _____ (initials)

Release of Information: I authorize the release of information collected by the center necessary for a coordination of clinical care and to process billing claims related to my care (or child/dependent stated above). _____ (initials)

Assignment of Benefits: I authorize payment of medical benefits to Sierra Family Health Center for professional services rendered. _____ (initials)

Your signature below indicates you have read, understand and agree to the payment policy, and consents.

Signed: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Additional Information—For Purposes of Grant Funding

The information you provide can help us recognize patients who may qualify for specially funded programs or services.

Marital Status:

- ☐ Divorced
- ☐ Married
- ☐ Partner
- ☐ Single
- ☐ Widowed
- ☐ Legally Separated
- ☐ Other _____

Sexual Orientation (For Patients Age 18 and Older):

☐ Heterosexual (Straight - not lesbian or gay) ☐ Homosexual (Lesbian or Gay) ☐ Bisexual

☐ Choose not to disclose ☐ Do not know ☐ Something Else Describe:_____

Gender you identify with:

- ☐ Female ☐ Male ☐ Choose to not disclose
- ☐ Transgender Male (Female-to-Male) Date of Transition: _____
- ☐ Transgender Female (Male-to-Female), Date of Transition: _____
- ☐ Gender queer, neither exclusively male nor female
- ☐ Additional gender category or other, please specify:_____

Race? Check all that Apply

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other Race
- ☐ Black/African American
- ☐ White
- ☐ Declined to Specify

Ethnicity: ◯ Hispanic/Latino: ◯ Non-Hispanic/Latino ◯ Unreported /Refused to report

Have you served in the military? ◯ Yes ◯ No

In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)? ____Yes ___No

Total number of people living in household: _____

Approximate total yearly income earned by family household: $_____

Would you consider yourself homeless at any time in the last 12 months? ◯ Yes ◯ No

If Yes, where:

- ☐ In your car
- ☐ On the street
- ☐ In a shelter
- ☐ With another family
- ☐ In a hotel
- ☐ Other_____

Where did you hear about our services?

- ☐ Family member
- ☐ Friend who loves the service!
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Social Media
- ☐ Insurance Company
- ☐ Flyer
- ☐ County Agency

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YOUR PRIVACY OPTIONS

Receipt of Privacy Practices & HIPAA Authorization

This form is to help us know whether you would like us to share information with the people in your life. Telling SFHC how you want to share information is called HIPAA Authorization and it's from the Health Insurance Portability and Accountability Act (HIPAA). This form also helps us to know that we have asked to give you our privacy practices. You are welcome to have a copy of our privacy practices.

Patient Information

Last Name: _____ First Name:_____ Middle Initial: _____

Nickname: _____ Date of Birth: _____

Name of Parent, Legal Guardian, or Conservator: (*Only if any of these apply to you.)*

_____

Messages: You allow SFHC to leave voice messages at the phone numbers you've given us. You can opt out of this service at any time.

Who to Share With: Please tell us with whom we can share, or release, information.

If you do not want ANYTHING told to or shared with ANYONE check here: ☐

Person #1: _____Relationship:_____

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

☐ Medical care ☐ Immunizations

Person #2: _____Relationship:_____

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

☐ Medical care ☐ Immunizations

Person #3: _____Relationship:_____

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

☐ Medical care ☐ Immunizations

Patient Sign: _____ Date: _____

Parent/Guardian/Conservator Sign: _____ Date_____

I have been asked if I want a copy of SFHC's Notice of Privacy Practices. _____ (initial)

This approval ends one year from the date signed or updated in writing.

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FINANCIAL POLICY

For Medical and Dental Services & Fees

All of us at Sierra Family Medical Clinic believe it is essential for you, the patient to understand the Clinic's expectations regarding the financial aspect of your visit.

Required at check-in:

1. Verify Personal Contact Information
2. Present Current Copy of Insurance Card
3. Present Current Picture ID (We ask for a copy of an ID card or license to help protect you from identify theft).
4. Payment of any Outstanding Balance
5. Payment of Today's Visit (Copays, coinsurance or deductible amounts and non-covered fees as identified by your insurance company are due at the time of service).
6. We take cash, check or credit card.

Insurance Billing:

Sierra Family Medical Clinic is a participating provider or considered in-network with a few plans; you can find out if the Clinic is with your plan by contacting your insurance company.

Learn what services and clinicians are covered before your visit by calling your insurance benefits department.

Sierra Family Medical Clinic will bill your insurance company for services provided.

You are responsible for any charges not paid by your insurance carrier.

Provide us with current information at every visit.

1. Up to date copy of your insurance card
2. A completed patient information sheet.
3. In the event that we cannot validate active coverage with your insurance carrier, your account will be considered self-pay.
4. Collect payment at time of service and refund any amounts subsequently collected from your carrier.
5. If you are insured by a non-participating insurance carrier, or if Sierra Family Medical Clinic is not the primary provider listed by your carrier, we will expect payment from you at time of service.
6. It will be your responsibility to submit any claims to your insurance company for direct reimbursement to you.
7. We will provide you with the appropriate information to assist you in this process.

If our clinicians or services are not listed in your plan's network (on their list of clinicians or services they have a contract with):

- ✓ You may have to pay for part of, or the entire bill.
- ✓ Your insurance might send the payment for you to bring and pay at your SFMC visit.

Please Remember:

1. **You must bring your insurance card to every visit.** We will need to copy both sides.
2. **If you have insurance**, we will send them the bill.
3. **If the insurance does not cover the fees** the patient will need to pay. If we get a payment from your insurance after you pay, we will refund what is due to you.
4. If you are **referred to another provider or other services**, any bills or fees you get from them will be between you and them. They may bill differently than we do at SFHC.
5. **Diagnostic tests** are billed separately.
6. Outstanding balances over 90 days may be referred to collections and you may be required to bring your balance current before your next appointment.

If your insurance does not cover part of your fee:

You might qualify for our sliding fee discount program for the things that are not covered. Medical and Dental have different rules.

If you have questions about your bill or fees our Billing Team is happy to help! Call us at (530) 292 3478 Ext 219.

I have read and understand the details of the SCHC Financial Policy.
Patient Name: _____ **Date:** _____

Sign (Patient or Account Holder)**:** _____

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Health History

Please help us get to know you better

Name: _____Date of Birth_____ Date:_____

Allergies: Are you allergic to any medicine or food? ◯ No ◯ Yes

If yes, please list:

Medicine or Food	What happens when you take or eat it?
Example: penicillin	I break out in hives
Example: peanuts	I can't breathe
1.	
2.	
3.	

Medications you take—Please bring all current medications including over the counter medications, vitamins and supplements to your first visit. If you did not bring them, please list below. You can also provide your medication list.

Medicines	Dose	How many times a day	Prescribing Doctor

Specialists You See:

Name	For what problems	City	Phone

Medical History: Do you have or have you been diagnosed and/or treated for any of the following conditions:

Yes	No	Health Condition	Yes	No	Health Condition
☐	☐	Anemia/blood disorder	☐	☐	Kidney/urinary tract problems
☐	☐	Arthritis	☐	☐	Liver problems or hepatitis
☐	☐	Blood clots	☐	☐	Lung problems
☐	☐	Bone/joint disease	☐	☐	Psychiatric illness _____
☐	☐	Cancer, where?_____	☐	☐	Skin problems
☐	☐	Diabetes, type _____	☐	☐	Stomach/bowel problems
☐	☐	Epilepsy/seizure disorder	☐	☐	Stroke
☐	☐	Eye disease, type _____	☐	☐	Thyroid, adrenal disease
☐	☐	Ear, nose or throat problems	☐	☐	Tuberculosis
☐	☐	Heart problems	☐	☐	Other:
☐	☐	High blood pressure	☐	☐	Other:
☐	☐	High cholesterol	☐	☐	Other:
☐	☐	HIV/AIDS	☐	☐	Other:

Surgical/Hospitalization History

Type of Surgery/Hospitalization	Year

Preventative Care

Date of last complete physical with bloodwork _____

Colonoscopy Yes___ No___ If yes, what year? _____

Females only: Have you had a mammogram? Yes___ No___ If yes, what year? _____

Have you had a Pap Smear? Yes___ No___ If yes, what year? _____

Past Immunizations (Shots): Have you had any of the following shots?

Flu Date: _____ Have the record? No Yes

Pneumonia Date: _____ Have the record? No Yes

Tetanus Date: _____ Have the record? No Yes

Please help us learn more about you so we can better help you:

- Do you have a dentist? Yes___ No ___
- Within the past 12 months, we worried whether our food would run out before we got money to buy more. Yes___ No ___
- Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. Yes___ No ___
- Do you feel safe at home? Yes___ No ___
- Have you fallen in the last year? Yes___ No ___
- Are you afraid of falling? Yes___ No ___
- Who lives with you? _____
- What is your level of education? _____
- What kind of work do you do? _____

Is there anything else you want to discuss with us today? _____

_____

Patient Name:_____ Date of Birth: _____

Family History: Have your close family members had any of the following?

Family Member	Medical Condition		
Mother ☐ Alive ☐ Passed Age: _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Father ☐ Alive ☐ Passed Age: _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other :	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Sister(s) # Alive: _____ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Brother(s) # Alive: _____ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Maternal Grandmother # Alive: _____ # Passed:_____ Age(s): ____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Maternal Grandfather # Alive: _____ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Paternal Grandmother # Alive: _____ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Paternal Grandfather # Alive: _____ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type_____ ☐ Depression Other:	☐ Diabetes: Type _____ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems

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Dental Screening for Medical and Behavioral Health Patients

Name: _____ Date: _____

Phone: _____ Date of Birth: _____

	Yes	No	If Yes, please describe
Are you having problems eating because of dental problems?	☐	☐	☐ less than 1 week or ☐ longer than 1 week
Do you have any mouth pain or any active dental problems today? If yes:	☐	☐	☐ less than 1 week or ☐ longer than 1 week
• Does it feel like tooth pain?	☐	☐	
• Does it feel like gum pain?	☐	☐	
• How long has this been going on?	☐	☐	
• Would you like to see our dentist for your dental problem if possible?	☐	☐	
Do you have any sores in your mouth or on your tongue?	☐	☐	
Do you have a dentist already?	☐	☐	
Do you have any major dental problems?	☐	☐	
Do you have dentures?	☐	☐	
How long has it been since you've seen a dentist?	☐ In the last year; or ☐ Over 1 year Number of years? _____		

Provider Use Only:

Referral: ☐ Warm Handoff to SFHC Dental ☐ Sent to their Own Dentist ☐ Not Required

Status: ☐ Urgent ☐ Emergent ☐ Routine ☐ Other _____

Provider Initials: _____

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Name: _____Date of Birth_____Date:_____

Please Circle Your Answers

SECTION I

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle your answers.)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling less interested in doing things you usually like to do	(0)	(1)	(2)	(3)
Feeling down, depressed, or hopeless	(0)	(1)	(2)	(3)

SECTION II

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	(1 -2)	(3-4)	(5-6)	(7-9)	(10+)
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	(Never)	(Less than monthly)	(Monthly)	(Weekly)	(Daily or almost daily)

SECTION III

In the past 12 months, have you used drugs other than those prescribed for medical reasons?	(Yes)	(No)
Have you taken non-prescription drugs to improve your thinking or help you deal with difficult emotions?	(Yes)	(No)
Have you taken drugs to forget work, school, or family pressures?	(Yes)	(No)
Have you continued to take non-prescription drugs to avoid the pain of withdrawal?	(Yes)	(No)
Do you have a difficult time getting through the week without using non-prescription drugs?	(Yes)	(No)

SECTION IV

Do you use tobacco?	Yes	No	
If no, have you ever used tobacco?	Yes	No	If yes, Quit Date_____
Do you vape?	Yes	No	

SECTION V

Do you have intense and persistent fear of a social situation in which people might judge you?	Yes	No
Do you fear that you will be humiliated by your actions?	Yes	No
Do you fear that people will notice that you are blushing, sweating, trembling, or showing other signs of anxiety?	Yes	No
Is your fear excessive or unreasonable?	Yes	No
Do you go to great lengths to avoid participating?	Yes	No
Have your symptoms interfered with your daily life?	Yes	No

SECTION VI

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**A few days**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	0	1	1	2	3
Not being able to stop or control worrying	0	1	1	2	3
Worrying too much about different things	0	1	1	2	3
Trouble relaxing	0	1	1	2	3
Being so restless that it is hard to sit still	0	1	1	2	3
Becoming easily annoyed or irritable	0	1	1	2	3
Feeling afraid as if something awful might happen	0	1	1	2	3

Is there anything bothering you today that you would like to talk to a counselor about today?	Yes	No

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Patient Rights and Responsibilities:

As a patient, you have the right to:

- take part in your health care and treatment.
- know the names of the people caring for you.
- be treated with respect and dignity in a safe and private setting.
- be informed about your illness and treatment, including options for your care.
- change medical providers at Sierra Family Health Center.
- get another opinion about your illness or treatment.
- privacy of your health records.
- talk with the clinic manager about any questions or problems with your care.
- know about services available through SFHC.
- receive respect for your cultural, social, spiritual and personal values and beliefs.
- know about legal reporting requirements.
- ask for special arrangements if you have a disability.
- ask for help with a living will or durable power of attorney for health care.
- refuse treatment, care and services as allowed by law.
- know the cost of your care and ways you may pay for your care.
- refuse to be included in any research program without limiting medical care or treatment.

As a patient, you have the responsibility to:

- tell your medical provider about your illness or problems.
- ask questions about your illness or care.
- show respect to both care givers and other patients.
- cancel or reschedule appointments so that another person may have that time slot.
- pay your bills on time.
- use medications or medical devices for yourself only.
- inform the medical provider if you become worse or you have an unexpected reaction to a medication.
- give written permission to release your other health records to Sierra Family Health Center when necessary.
- provide SFHC a copy of your living will or durable power of attorney for healthcare matters.

If you have any questions, please tell your medical provider or the clinic manager.

SFHC Hours:
Oregon House: Monday, Tuesday and Thursday: *8:30AM—4:30 PM*
Tyler Foote: Monday-Friday: *8.30AM—5:00PM* and Saturday: *10AM--1PM*

Phone: 530.292.3478
Fax: 530.292.4296
Email: info@sierraclinic.org

Your Patient Portal

Your patient portal is a secure website where you can view and update your personal and health information, as well as communicate with Sierra Family!

You now have convenient, safe and secure access to:

View

- Your visit summaries
- Current medications
- Upcoming appointments
- Lab results
- Educational materials
- Messages from the practice

Update

- Personal information
- Phone number, address, and emergency contacts
- Preferred pharmacy

Communicate

- Send a general message to your provider
- Request medication refills
- Download your available health records
- Transmit your available medical records to another provider
- Request a new appointment

To access your portal, simply give your email address to a team member of Sierra Family

Within an hour, you will receive an email with instructions on setting up your personal patient portal.

Sierra Family Health Center

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You Can Help Support Sierra Family Health Center

At no cost to you!

Please Use One of Our Preferred Pharmacies:
Simply go to one of our preferred pharmacies, listed below, for your medications and SFHC will receive a small rebate on your purchase, at no cost to you! All you need to do is fill your prescriptions—you don't even have to tell them you're a patient with SFHC.

CVS Pharmacy
1005 Sutton Way, Grass Valley CA 95945
906 E Main Street, Marysville CA 95901
1274 Stabler Lane, Yuba City CA 95993
11411 Deerfield Drive, Truckee CA 96161
388 Elm Avenue, Auburn CA 95603

Raley's Pharmacy
692 Freeman Lane, Grass Valley

Rite Aid Pharmacy
720 Sutton Way, Grass Valley CA 95945

Save Mart Pharmacy
2054 Nevada City Highway, Grass Valley

Frequently Asked Questions

Q: Will it cost me more to go to one of these preferred pharmacies?

A: No. The cost to you should be the same at preferred pharmacies as at any other pharmacy. The rebate is covered by drug companies at zero cost to you.

Q: Do I need to tell the pharmacy that I am a patient at SFHC, and I want to use the rebate program?

A: No—the pharmacies will automatically know that you are a patient with us, and will give us the rebate without you saying anything.

Q: Should I ask to have my prescriptions transferred right away?

A: You can start with any prescriptions you receive at your visit today, or have us refill one of your ongoing medications. Please tell your healthcare provider which preferred pharmacy you would like to use. Then, at your convenience, you can ask that pharmacy to get all your prescriptions transferred there.

If you have any other questions, please ask your medical assistant or healthcare provider at your visit today.

Thank you for considering our preferred pharmacy program!