Town & Country
Compounding and Consultation

"Customized, Patient Specific, Compounded Medications"

# Pharmacy/Health Consultation Services Statement

| Patient Information | | | |
|---|---|---|---|
| Name | | | Phone |
| Address | | | |
| City | | State | Zip |
| Birth Date | Sex | SSN/Subscriber ID No. | |

I hereby authorize release of information to health care providers, institutions, and/or payers that may pertain to my illness and/or treatment received. I certify that the information I have reported with regard to my insurance coverage is correct, and I have received the pharmacist care/services rendered.

***Patient Authorization:*** _____ ***Date:*** _____

| Visit Type | CPT | Fee |
|---|---|---|
| New Patient Comprehensive (60 min) | 99204 | |
| New Patient Intermediate (20-45 min) | 99202 | |
| New Patient Brief (<20 min) | 99201 | |
| Established Patient Comprehensive (60 min) | 99214 | |
| Established Patient Intermediate (20-45 min) | 99212 | |
| Established Patient Brief (<20 min) | 99211 | |
| Administration/Interpretation of HRA | 99420 | |
| Self-Care Consultation/Training | 97535 | |
| Services Requested After Hours | 99050 | |
| Services Requested on Sundays & Holidays | 99054 | |
| Other | | |

| Medication Screening | | Fee |
|---|---|---|
| Verify Appropriate Strength | | |
| Verify Appropriate Quantity | | |
| Verify Appropriate Directions for Use | | |
| Review Patient Allergy Profile | | |
| Review Patient Medical Condition | | |
| Screen for Possible Drug-Drug Interaction | | |
| Screen for Possible Drug-Disease Interaction | | |
| Screen for Duplicate Therapy | | |
| **Detailed Medication Counseling** | | $ |
| Other | | |
| | | |

| Detected Problem | Fee |
|---|---|
| Product Needed, Not Prescribed | |
| Product Prescribed, Not Needed | |
| Prescribed Dose Above Maximum | |
| Prescribed Dose Below Minimum | |
| Prescribed Schedule Above Maximum | |
| Prescribed Schedule Below Minimum | |
| Prescribed Duration Above Maximum | |
| Prescribed Duration Below Minimum | |
| Prescribed Product Contraindicated | |

| Provider Actions | Fee |
|---|---|
| Contact Prescriber/Prescriber's Agent | |
| Consult with other Health Care Professional | |
| Research Reference Materials | |
| Counsel Patient/Patient's Care Giver | |
| Provide Patient Education/Demonstration | |
| | |
| | |
| | |
| | |
| **Patient Total $** | |

| Pharmacy Information | |
|---|---|
| **Town & Country Compounding & Consultation** | |
| **Pharmacist Name:** **John Herr, RPh, FIACP** | **Date of Service:** |
| **Pharmacist Signature:** | **License #** **R118042** |

**I certify that the above services have been rendered and the fees submitted are those that have been charged to the indicated patient.**

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