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	Medication Screening		Fee
New Patient Comprehensive (60 min)	99204		Verify Appropriate Strength		
New Patient Intermediate (20-45 min)	99202		Verify Appropriate Quantity		
New Patient Brief (<20 min)	99201		Verify Appropriate Directions for Use		
Established Patient Comprehensive (60 min)	99214		Review Patient Allergy Profile		
Established Patient Intermediate (20-45 min)	99212		Review Patient Medical Condition		
Established Patient Brief (<20 min)	99211		Screen for Possible Drug-Drug Interaction		
Administration/Interpretation of HRA	99420		Screen for Possible Drug-Disease Interaction		
Self-Care Consultation/Training	97535		Screen for Duplicate Therapy		
Services Requested After Hours	99050		**Detailed Medication Counseling**		$
Services Requested on Sundays & Holidays	99054		Other		
Other					

Detected Problem	Fee	Provider Actions	Fee
Product Needed, Not Prescribed		Contact Prescriber/Prescriber's Agent	
Product Prescribed, Not Needed		Consult with other Health Care Professional	
Prescribed Dose Above Maximum		Research Reference Materials	
Prescribed Dose Below Minimum		Counsel Patient/Patient's Care Giver	
Prescribed Schedule Above Maximum		Provide Patient Education/Demonstration	
Prescribed Schedule Below Minimum			
Prescribed Duration Above Maximum			
Prescribed Duration Below Minimum			
Prescribed Product Contraindicated			
Pharmacy Information		**Patient Total $**	

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.
<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<

© *2003 International Academy of Compounding Pharmacists*. All rights reserved.

106 Prospect Street, Ridgewood, NJ 07450 Ofc: 201-447-2020 Fax: 201-447-3253
www.tccompound.com tompellegrino@tccompound.com