



St. John's Military School

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ENROLLMENT FOR B&K PRESCRIPTION SHOP

601 E. Iron, Salina, Kansas 67401 • 785.827.4455

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Cadet Information

Last Name _____ First _____ MI _____
Date of Birth _____ Height _____ Weight _____
Emergency Contact _____ Phone _____
Hometown Physician _____ Address _____

Responsible Party

Last Name _____ First _____ MI _____
Mailing Address _____
City _____ State _____ Zip _____
Phone Number _____ Email Address _____
Work Phone _____ SS# _____

Insurance Information

Cardholder Name _____
Employer or Group Name _____ Company _____
ID Number _____ Group Number _____
Person Code # _____ SS # _____

(Please include a copy of the front and back of your prescription card)

Insurance Payment Agreement

The undersigned (insured/responsible party) _____

Hereby agrees to the following:

Whereas B&K Prescription Shop, at the insured's request & as a courtesy to the insured, has agreed to bill the insured's company for prescribed medication and other medical related items prescribed by the insured's physician and accept assignment on the anticipated insurance payment.

I authorize B&K Prescription Shop to directly receive payment for my purchases and to give the necessary information to receive such payment.

I also hereby agree that if the insurance company makes payment directly to me, the insured, to remit that sum immediately to B&K Prescription Shop. I also acknowledge final responsibility for the prescription medication and supplies provided and agree to pay the deductible amount and other amounts that the insurance company does not pay B&K Prescription Shop and I understand that B&K Prescription Shop will bill me for the balance of the prescriptions.

Signature of Insured/responsible party _____ Date _____