# Group Session Individual Consent and Registration

**Patient name:** _____ **Date:** _____

**Address:** _____

**Phone Numbers:** _____
(home) (cell) (work)

**Gender:** ❑Female ❑Male **Date of Birth:** _____
(day/month/year)

**Health Services Number:** _____ **Email:** _____

## Declaration of Consent

**I agree to receive services under the PACT program by my pharmacist and allow my information to be released to or from another health care provider as necessary for my care.**

**Date:** _____ **Patient Signature:** _____

**Notes:**

❑ Patient has requested individual PACT counseling or follow-up

## *Pharmacist Use Only*

**Pharmacist Name:** _____ ❑ **Service Billed**

**Billable Minutes:** _____ (max 3 submissions totalling 150 minutes @ $1.00/minute every 365 days

**Date of Next Contact:** _____