Ready Meds Pharmacy
Renton • Spokane • Lacey • Everett • Vancouver

1412 SW 43RD STREET · Suite 120 · Renton, WA 98057
· (877) 425-6337 Phone www.readymedspharmacy.com
· (877) 509-6337 Fax newadmit@readymedspharmacy.com
www.facebook.com/readymedspharmacy

NEW CLIENT INTAKE FORM

Please complete and fax or E-Mail this form along with copy of medication list or discharge orders to 877-509-MEDS or NewAdmit@readymedspharmacy.com

Must submit before medications can be delivered

INTERNAL USE:
Facility Code: _____ ☐ ALF
Received Date: _____
Delivery Date: _____
Packaging:
☐ Bingo ☐ Multi-pack ☐ Bottle ☐ HOA
eMAR
☐ ECP ☐ QuickMAR ☐ Synkwise ☐ Other

Facility/Delivery Information

Name:_____ Phone Number:_____

Address:_____ City:_____ Zip Code:_____

Fax Number:_____ Email:_____

Owner/Main Contact Name:_____

Resident Medical Information

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ Social Security Number:_____ Gender: M ☐ F ☐

Chronic Conditions: _____

_____

Allergies:_____ ☐ No Known Drug Allergies

Physician Info

Primary Physician Name:_____

Physician Phone #:_____

Physician Fax #:_____

Pharmacy Info

Previous Pharmacy:_____

Pharmacy Phone #:_____

For Specialist Physicians please attach a list

Discharge Info

Resident Discharging From:

Hospital_____

SNF/ALF_____

AFH_____

Patient's Own Residence_____

(1) Current Supply of Meds on Hand:
_____ Days

(2) When is Resident Moving into your Facility?
_____ Date

Resident Insurance Information

Primary Insurance Company: _____

Policy ID:_____

Bin#:_____ PCN#_____

Rx Group#:_____

Medicaid DSHS/Provider One Card#:_____

Medicare MBI#: _____

or

ATTACH COPIES OF FRONT & BACK OF PATIENT'S INSURANCE CARDS

Mon-Fri 8am to 9pm · Sat/Sun/Holidays 9am to 5pm · On Call Answering Service available 24 hours for emergency only

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PHARMACY SERVICES PROVIDER AGREEMENT

Patient Name:_____ ***Patient D.O.B.:***_____

I authorize Ready Meds Pharmacy (referred to in this agreement as the "Pharmacy") to provide medications and associated products and services to the above-named patient (referred to in this agreement as "The Patient"). I certify that I have the legal authority to sign this agreement on behalf of said patient and I understand that by signing this agreement I will become responsible to pay the usual and customary fee for all medications, products, and services provided to The Patient by The Pharmacy at the direction of the facility administration and staff and attending physician(s). If I disagree with any medication, product or service directed by the facility or an attending physician, I will contact them and resolve the issue(s) and ask them to provide different written direction to The Pharmacy. I acknowledge and agree that The Pharmacy will provide medications, products and/or services based upon the most current written direction received.

For patients receiving benefits from an insurance company (referred to in this agreement as a Pharmacy Benefits Manager "PBM"), I am aware that The Pharmacy will bill the PBM for all medications, products and services covered by the PBM and that I am responsible for any co-payments that may arise. I am aware that I am also responsible for payment for all medications, products and services provided by The Pharmacy that are not covered by the PBM. I understand and agree to the following:

- Medications furnished to The Patient are not packaged in child- proof containers.
- The facility personnel are authorized to order products and services on behalf of The Patient.
- To pay all charges incurred by The Patient that are not paid for by their PBM, including Medicare and Medicaid.
- Medications that are delivered to the above-named facility and subsequently discontinued or modified by The Patient's physician or otherwise not used by The Patient for any reason cannot be returned for credit. I understand that all medications, once delivered are not returnable per WAC 246-869-130, and I will be responsible for the full amount due.
- Statements printed at the beginning of the month are for products and services that were rendered the previous billing cycle, therefore should The Patient move out of the above-named facility or pass away I am still obligated to pay the final balance. I agree to pay the entire amount due before the statement due date unless prior arrangements were made with The Pharmacy's billing department.
- To notify The Pharmacy immediately if The Patient's PBM changes.
- To notify The Pharmacy immediately if The Patient passes away, hospitalize, or relocates to another facility.
- Before a full profile transfer to another pharmacy can occur, I must pay down The Patient's account to zero.
- If full payments are not received by the end of the month, I agree to pay a finance charge of 2.00% per month or a minimum service charge of $5.00 whichever is greater on the leftover balance.
- If no payment or partial payment were received for the previous month, The Pharmacy may reserve the rights to refuse services for The Patient until balance has been paid off.
- If my account becomes 90 or more days delinquent, The Pharmacy will freeze The Patient's account. No more products or services will be rendered until balance has been paid off.
- If my account becomes 120 or more days delinquent, The Pharmacy may reserve the rights to send my account to collection.
- To pay all costs of collection, including court costs and attorney fees, for all delinquent balances. There will be a closing fee of 50% of the final balance upon closing of the account.
- Multiple Delinquencies within a short period of time may result in requiring an auto payment method to be put on file for continuation of services.

Assignment of Benefits

I hereby request that payment of authorized insurance benefits be made on The Patient's or my behalf to The Pharmacy for medications, products and/or services furnished to The Patient. I authorize The Pharmacy to release any necessary or required personal health information to the Center for Medicare and Medicaid Services, any health insurance company, and/or their agents for the purpose of determining benefits or resolving any question regarding coverage ***AND*** I hereby acknowledge that I have received a copy of The Pharmacy's Notice of Privacy Practices (HIPPA), Patient Rights & Responsibilities and CMS Medicare DMEPOS Supplier Standards and understand each respective party's rights.

Responsible Party Print Name:_____ ***Relationship:***_____
Address:_____ ***Phone Number:***_____
_____ ***Email:***_____

Signature ***Date:***
X:_____ _____
(By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.)

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Credit Card Authorization Form

Please print and complete all the information below.

Patient's Name:
Patient's Date of Birth:
Patient's Facility:

Name on Card:
Billing Address:
Billing City:
Billing State:
Billing Zip Code:
Email (optional):

Card Number:
Expiration Date:
CVV:
Type of Card: ☐ VISA ☐ MC ☐ AMEX ☐ DISC

I _____,
authorize Ready Meds Pharmacy to charge my credit card, outlined above, for any balance owed on the monthly statement for the client above. I understand that I will continue to receive monthly statements for my information and review. I acknowledge that Ready Meds Pharmacy will be storing my account on a secure server for billing purposes only.

I understand that upon receiving notification of the client leaving the facility or passing away, Ready Meds Pharmacy will charge any remaining balance on the client's file to close out the account.

I agree to pay the Pharmacy a fee of $40.00 if for any reason I issue a chargeback with my credit card company.

Patient / POA Signature:
Patient / POA Printed Name:
Date: