1412 SW 43RD ST #120
RENTON, WA 98057
PHONE (877) 425-6337
FAX (877) 509-6337

Ready Meds Pharmacy Rx
www.ReadyMedsPharmacy.com

NEW CLIENT INTAKE FORM

Please complete and FAX or email with a copy of the medication list or discharge orders to Fax (877) 509-6337 or newadmit@readymedspharmacy.com

⚠ FORM MUST BE FILLED TO DISPENSE MEDICATIONS

1. FACILITY INFORMATION

NAME			
ADDRESS	CITY	STATE	ZIP
EMAIL		PHONE	
OWNER/CONTACT NAME		FAX	

2. RESIDENT INFORMATION

LAST NAME		MIDDLE INITIAL	FIRST NAME	
DOB	SSN	GENDER	☐ MALE	☐ FEMALE
CHRONIC MEDICAL CONDITION				
ALLERGIES			☐ NO KNOWN DRUG ALLERGIES	

3. RESIDENT DISCHARGE INFORMATION

☐ HOSPITAL	☐ SNF / ALF	☐ AFH	NAME OF FACILITY	☐PRIVATE RESIDENCE
CASE MANAGER / SOCIAL WORKER			PHONE	
DAY(S) SUPPLY OF MEDICATIONS ON HAND			DATE OF ARRIVAL AT FACILITY	

4. PHYSICIAN INFORMATION

PCP NAME	PCP PHONE	PCP FAX
SPECIALIST NAME	PHONE	FAX
SPECIALIST NAME	PHONE	FAX

5. PREVIOUS PHARMACY INFORMATION

NAME	PHONE

6. RESIDENT INSURANCE INFORMATION

PRIMARY INSURANCE		POLICY ID	ATTACH COPIES OF FRONT AND BACK OF RESIDENT'S INSURANCE CARDS AND COPY OF POA DOCUMENT
BIN	PCN	RX GROUP	
MEDICAID DSHS / PROVIDER ONE ID			

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PATIENT BILLING AUTHORIZATION FORM

Please complete and FAX or e-mail to
Fax (877) 509-6337 or newadmit@readymedspharmacy.com

PATIENT NAME	**DATE OF BIRTH**

I authorize Ready Meds Pharmacy (the "Pharmacy") to provide medications, products, and services to the above patient (the "Patient"). I certify I have legal authority to sign on behalf of The Patient. The Pharmacy dispenses medications based on directions from the facility and attending physician(s). If I disagree with an order, I will contact the facility or physician for updated written instructions. The Pharmacy will bill the patient's insurance for covered medications. I understand I am responsible for co-pays and any medications, products, or services not covered by insurance.

1. PATIENT ACCOUNT POLICIES

- Medications furnished to the Patient are not packaged in child-proof containers.
- Facility staff may order medications or services for the Patient.
- Medications cannot be returned once delivered per Washington law WAC 246-945-485.
- I am responsible for all charges not paid by insurance.
- Monthly statements are for items processed before the statement date.
- If the Patient moves, relocates, is hospitalized, or passes away, the Pharmacy must be notified immediately, and the final balance for any items sent before notification will be charged.
- Any outstanding balances remain the responsibility of the responsible party even if prescriptions are transferred.
- Past-due balances may incur a 2% monthly finance charge or $25 minimum late fee, whichever is greater on the remaining balance.
- Accounts 90 days delinquent may be frozen and sent to collections, including court costs and attorney fees. A closing fee up to 50% of the final balance may apply.

2. RESPONSIBLE PARTY

NAME		RELATIONSHIP	
BILLING ADDRESS	CITY	STATE	ZIP
PHONE	EMAIL		

3. SELECT ONE BILLING OPTION BELOW

☐ **OPTION 1: CREDIT CARD AUTHORIZATION**	BILLING ADDRESS		
CARDHOLDER NAME	CITY	STATE	ZIP
CREDIT CARD #	EXP		CVV

I understand monthly statements are generated and charged at the start of the month. By signing below, 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 agree to a $40 chargeback fee if a credit card dispute is filed.**

☐ OPTION 2: DO NOT SEND ANYTHING THAT COSTS MONEY

Do not send medications, products, or services that require payment.
I understand the Pharmacy will not send medications not covered by insurance or medications with copays, will not call for permission, and it is my responsibility to coordinate payment with the facility if items that cost money are needed.

4. ASSIGNMENT OF BENEFITS

I authorize payment of insurance benefits directly to Ready Meds Pharmacy and authorize release of necessary health information to Medicare, Medicaid, or insurance companies to determine coverage. I acknowledge receipt of the Pharmacy's HIPAA Privacy Notice, Patient Rights & Responsibilities, and CMS Medicare DMEPOS Supplier Standards.

⚠ SIGNATURE REQUIRED TO DISPENSE MEDICATIONS

By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.

CARDHOLDER SIGNATURE	**DATE**