Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
VANCOUVER • MOUNTLAKE TERRACE

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

Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
VANCOUVER • MOUNTLAKE TERRACE

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

HOW DO YOU WANT TO PAY?
(Must choose one)

Email to send Payment: _____

☐ **OPTION 1 – AUTOPAY WITH CREDIT CARD OR CHECKING ACCOUNT**

- **Please complete our Credit Card Authorization Form (Page 3)**
  - ✓ **Please attach a copy of the front AND back of your driver's license.**
- **Please complete our ACH Authorization Form (Page 4)**
  - ✓ **Please attach a voided check.**

-

☐ **OPTION 2 – PUT DOWN A SECURITY DEPOSIT AND RECEIVE MONTHLY STATEMENTS**

- **Please complete our Deposit Authorization Form (Page 5)**
  - ✓ **The Pharmacy will determine what deposit amount is required.**
  - ✓ **The Pharmacy will send a statement with the required deposit amount.**

-

☐ **OPTION 3 - DO NOT SEND ANYTHING THAT COST MONEY**

- **Please complete the Do not send anything that costs money Authorization Form (Page 6)**
  - ✓ **We will not send any items not covered by insurance.**
  - ✓ **We will not send any items covered by insurance with copays.**
  - ✓ **We will not call for permission to send items that cost money.**
  - ✓ **You are responsible for coordinating with the facility to supply items that cost money.**

Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
VANCOUVER • MOUNTLAKE TERRACE

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

Credit Card Authorization Form

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 directions 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 or caregivers 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 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 246-945-485, 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 moves, leaves The Pharmacy's service, or passes 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 location.
- 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 $25.00 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 the balance has been paid off.
- 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.
- I understand that upon receiving notification of the client leaving The Pharmacy's services or passing away, Ready Meds Pharmacy will charge any remaining balance on the client's file to close out the account.

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.

Billing Address: Phone Num:

Cardholder Name: Email:

Card Num: EXP: CVV: Zip Code:

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

Cardholder Signature: Date:

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

Ready Meds Pharmacy Rx
RENTON • SPOKANE • LACEY • EVERETT
VANCOUVER • MOUNTLAKE TERRACE

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

ACH Authorization Form

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 directions 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 or caregivers 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 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 246-945-485, 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 moves, leaves The Pharmacy's service, or passes 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 location.
- 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 $25.00 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 the balance has been paid off.
- 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.
- 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.

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.

Billing Address + Zip Code: Phone Num:

Account Holder Name: Email/Fax:

Routing Number: Account Number:

By signing below, I authorize Ready Meds Pharmacy to charge my checking account, 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 pay the Pharmacy a fee of $40.00 per RCW 62a.3-515 (b)(1) if for any reason my payment is not honored by my financial institution.

Account holder Signature: Date:

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

Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
VANCOUVER • MOUNTLAKE TERRACE

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

Deposit Authorization Form

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 directions 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 or caregivers 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 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 246-945-485, 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 moves, leaves The Pharmacy's service, or passes 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 location.
- 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 $25.00 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 the balance has been paid off.
- 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.
- The deposited amount is the patient's credit limit. If charges go over the limit, the account will be put on hold until payments are made to bring the balance below the limit. Additional deposits can be added to the account later to increase the credit limit.
- The deposited amount will be determined by the pharmacy and the requested amount will be printed on the Deposit Statement.
- The deposit amount will only be used to pay any closing balances when the patient stops using Ready Meds Pharmacy. I know the deposit amount does not affect the monthly statement balance of the patient in any way. I will pay the full amount due on each statement before the deadline.
- Any remaining credits after closure of the account with The Pharmacy will be sent to the agreed address below as a refund check.

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.

Billing Address: Phone Num:

Depositor Name: Email/Fax:

Depositor Signature: Date:

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

Ready Meds Pharmacy
RENTON • SPOKANE • LACEY • EVERETT
VANCOUVER • MOUNTLAKE TERRACE

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

Do not send anything that cost money Authorization Form

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 The Patient. 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 directions 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. I understand that by signing this agreement I will direct The Pharmacy not to send any medications, products, and services which will result in The Patient having to pay out of pocket expenses.

I understand and agree to the following:

- The Pharmacy will not send any items, medications, products and/or services not covered by insurance.
- The Pharmacy will not send any items, medications, products and/or services covered by insurance with copays.
- The Pharmacy will not call for permission to send items, medications, products and/or services that cost money.
- It is your responsibility to coordinate with the facility to supply items, medications, products and/or services that cost money.
- If an item, medications, products and/or services that cost money is sent, payment is required immediately.
- If an item, medications, products and/or services that cost money is sent monthly, a new form (autopay or deposit) is required.
- Medications furnished to The Patient are not packaged in child- proof containers.
- The facility personnel or caregivers 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 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 246-945-485, 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 moves, leaves The Pharmacy's service, or passes 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 location.
- 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 $25.00 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 the balance has been paid off.
- 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.

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:	
Billing Address:	Email/Fax:	
Responsible Party Signature:	Phone Num:	Date:

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