Prime Pharmacy

Address: **64 Rainier Ave S Unit H**
Renton, WA 98057
Phone: **206-829-4908**
Fax: **206-829-4906**
Email: **info@theprimepharmacy.com**
Website: **theprimepharmacy.com**

NEW CLIENT INTAKE FORM

Please complete and fax or E-Mail this form along with copy of medication list or discharge orders to 206-829-4906 or info@theprimepharmacy.com

INTERNAL USE:
Facility Code: _____
Received Date: _____
Delivery Date: _____
Packaging:
☐ Bingo ☐ Multipack ☐ Dispill ☐ HOA

Facility Information

Name: _____ Phone Number: _____
Address: _____ Fax Number: _____
_____ E-Mail: _____
Owner/Contact Name: _____ Other Phone Number: _____

Resident Medical Information

Last Name: _____ MI: _____ First Name: _____
Date of Birth: _____ Social Security Number: _____ Gender: ☐ M ☐ F
Chronic Conditions: _____
_____
Allergies: _____ ☐ No Known Drug Allergies

Physician Info

Primary Physician Name: _____
Physician Phone #: _____
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?
_____

Responsible Party / Payee Information

Responsible Representative Name: _____ Relationship: _____
Please check all that apply:
☐ Medical Decisionmaker ☐ Financial Payee ☐ Both ☐ Patient is Self-POA/Payee
*Must provide credit card if patient has copays/charges
Billing Address: _____ _____
Phone Number: _____ E-Mail: _____

Resident Insurance Information

Primary Insurance Company: _____
Policy ID: _____
RxGroup#: _____ Bin#: _____ PCN: _____
Medicaid DSHS / Provider One Card#: _____
Medicare Part B#: _____

or

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

PHARMACY SERVICES PROVIDER AGREEMENT

Patient Name: _____**Agency/Facility Name**:_____

I, _____ authorize Prime Pharmacy (referred to in this agreement as the "Pharmacy") to provide medications and associated products and services to the above-named 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 provides medications, products or services based upon the most current written direction received by it. 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 apply and/or for the payment for all medications, products and services provided by the Pharmacy that are not covered by the PBM. Should I arrange for home health and/or hospice services and supplies, I understand that Medicare will not reimburse me or my supplier and I will be responsible for their cost as well. In addition, I also understand that the medications furnished to the above-named resident are not packaged in child- proof containers. I agree that the facility personnel are authorized to order purchases and charges on behalf of the above-named resident. I agree to pay all charges incurred by the above-named resident that are not paid for by third party payers, including Medicare and Medicaid. I understand that medications that are delivered to the above-named facility and subsequently discontinued or modified by the above-named resident's physician or otherwise not used by the above-named resident 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. I understand that statements printed at the beginning of the month are for medications sent the previous month, therefore should the above-named resident move out the above-named facility or pass away I am still obligated to pay the final balance by the end of the statement month. I agree to pay the entire amount due by the end of the statement month unless prior arrangements were made with the Pharmacy's billing department. 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. I understand that if no payment or partial payment were received for the previous month, the Pharmacy may reserve the rights to refuse services for the above-named resident. If your account becomes 120 or more days delinquent, the Pharmacy may reserve the rights to send your account to collection. I agree 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 agree to pay the Pharmacy a fee of $40.00 per RCW 62A.3-515 (b)(1) if for any reason a check issued for the above-named resident is not honored by the financial institution. Prime Pharmacy does not accept postdated checks.

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), Routinely Purchased Items Notification, Equipment Warranty Information, patient Rights & Responsibilities and CMS Medicare DMEPOS Supplier Standards and understand each respective party's rights.

Signature X:_____ **Date:** _____

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

Responsible Party Print Name:_____ **Relationship**:_____

Address: _____**Phone Number**:_____

_____**Email**: _____

*** CREDIT CARD AUTHORIZATION FORM ***

I understand that the Pharmacy can provide for regular automatic payments from an established credit card. I authorize the Pharmacy to charge automatically to my credit card monthly payments owed on the monthly statement for the above client. I understand that I will continue to receive a monthly statement for my information and review. I acknowledge that the Pharmacy will be storing my credit card information on a secure server for billing purposes only. I understand that upon receiving notification of the client above leaving the facility above, the Pharmacy will charge any remaining balance on the client's file to close out the account. I understand that to cancel this arrangement, I will have to contact the Pharmacy directly.

Card Type

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Name of cardholder: _____

Card Number: _____ Billing Address: _____

Card Exp: _____Security Code (cvv): _____City: _____ State: _____Zip Code: _____