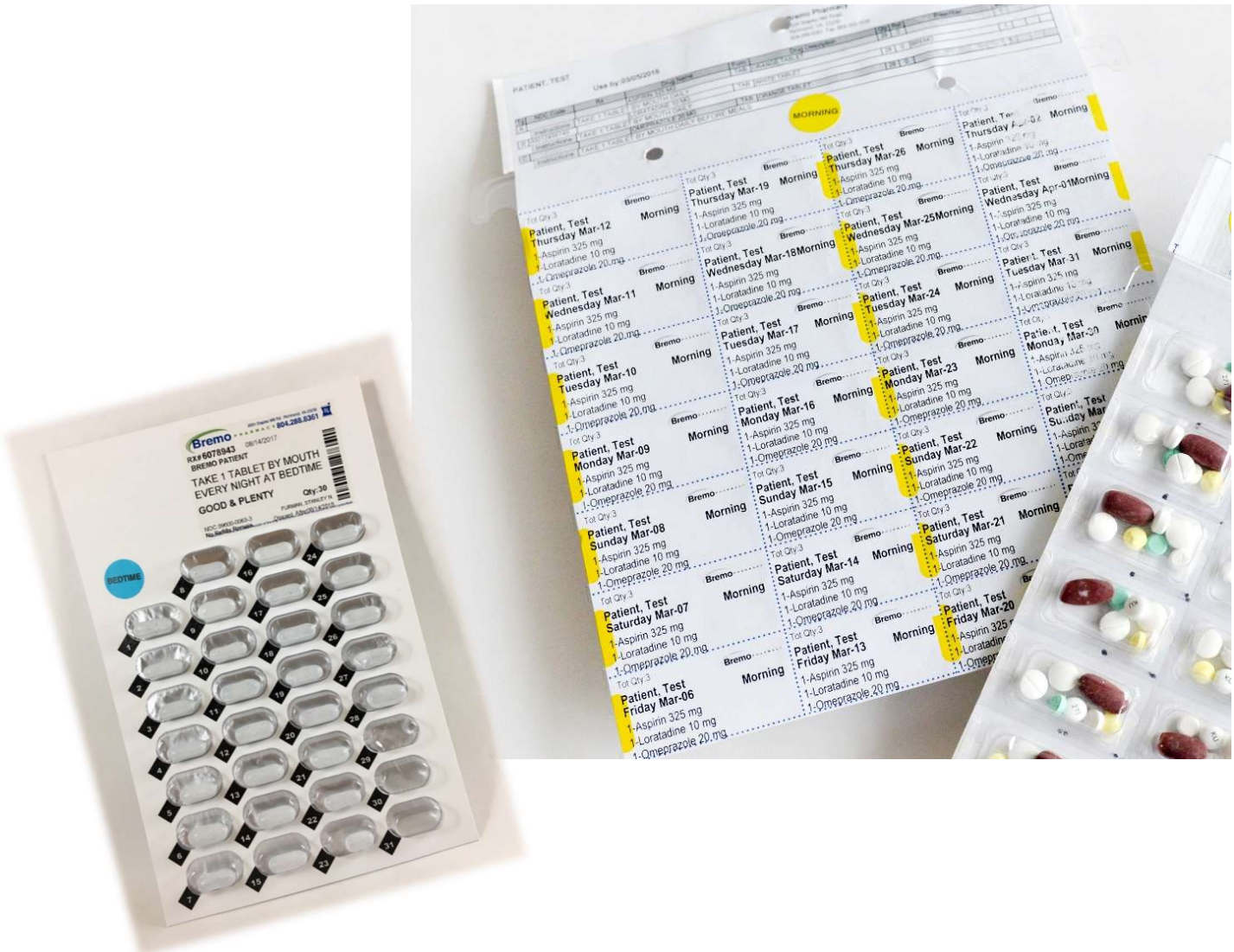
Bremo PHARMACY
@ HENRICO DOCTORS

Small Pharmacy...Big Hearts
www.BremoRX.com
1602 Skipwith Rd #201 Richmond, VA 23229
Tel 804.285.7730 / *Intra-Hospital* *94727 / *Fax* 804.285.8769

SYNC RX

PATIENT ENROLLMENT FORM



I request that payment of authorized Medicare or other Health Insurance Payer benefits be made either to me or on my behalf for any services furnished me by or in Richmond Apothecaries, Inc. Pharmacies (Bremo, Bremo LTC, or Bremo Pharmacy @ Henrico Doctors), including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or other Health Insurance Payer and its agents any information needed to determine these benefits or for related services. I recognize that in the event that the insurance carrier does not pay for this service or reimbursement is sent to me rather than to the pharmacy, I am responsible for payment.

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Pharmacy Copy, please read and sign

Agreement to Participate in the Synchronized Prescription Refill Service

Thank you for your interest in the SyncRx at Bremo Pharmacy. Advantages of participating in the program include:

- Increased convenience—a single monthly trip to the pharmacy or delivery
- Peace of mind from being able to get medications on time and in one order
- More personal contact with your pharmacist to ask questions and discuss medications
- Increased understanding of your medication, its purpose, potential side effects and costs.
- Your prescription records can be more easily updated to reflect changes in therapy made by doctors or upon hospital discharge.
- Monthly Pocket Medication lists
- Benefits offered: waived packing fees, waived delivery fees, waived medication disposal

I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the service. *I hereby agree:*

- To accept a monthly phone call from Bremo pharmacy to discuss my chronic prescription refills.
- To pick up medications or accept a delivery on my assigned refill date.
- **To keep an open dialogue with my pharmacist regarding doctor's appointments, hospital/urgent care visits, and changes in my health status, or address.**
- To inform the pharmacy of any changes in contact information or address.
- If necessary, to pay an extra co-pay *one time* for each medication in order to make all refills due on the same day.

I have read this document, understand it, and have had all questions answered satisfactorily.

Please ensure all fields are complete to ensure accuracy of enrollment.

- ❑ Patient request Dispill (multidrug) 30 day packaging OR
- ❑ Patient requests Bubble packing 30 day individually per drug OR
- ❑ Bottles
- ❑ Home Delivery
- ❑ MAR; HOA= _____
- ❑ Other special needs: _____

_____
Patient Name (*Please print*)

_____ _____
Patient Signature Date

_____ _____
Pharmacist Signature Date

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New Patient Information Form

Name _____ ___ _____ Date of Birth ____ /____ /____
First MI Last Name mm dd yy

SSN _____ ❑Male ❑Female

Address _____ _____ __ _____
Street City State Zip Code

Phone _____ - _____ - _____ ❑ This is my preferred form of contact

E-Mail _____ ❑ This is my preferred form of contact

Family Contact: _____ Relation :_____

Phone : _____-_____-_____ ❑ I give my consent to contact regarding my prescriptions/payments

Primary Care Physician _____

➔ ***** Drug Allergies ❑ no ❑ yes, describe reaction: _____

➔ How did you hear about our program:_____

Primary Prescription Insurance Information

Plan Name: _____ RX BIN:_____ RX PCN:_____

ID #: _____ RX GROUP: _____

Secondary Prescription Insurance Information

Plan Name: _____ RX BIN:_____ RX PCN:_____

ID #: _____ RX GROUP: _____

Pharmacy Help-Desk Phone #: _____

Preferred Method of Payment: ❑Cash on Delivery ❑ Credit Card ❑ Check

Please check the following health conditions you have

❑ Acid Reflux (GERD)	❑ Kidney disease	❑ Liver disease
❑ Anxiety	❑ Emphysema	❑ Parkinson's disease
❑ Arthritis	❑ Glaucoma	❑ Previous heart attack
❑ Asthma	❑ Hardening of arteries	❑ Previous stroke
❑ Bipolar disorder	❑ Headaches	❑ Schizophrenia
❑ Cancer	❑ Hypothyroid	❑ Seizures
❑ Chest pain (Angina)	❑ Hyperthyroid	❑ Sexual dysfunction
❑ COPD	❑ Irregular heart beat (Arrhythmia)	❑ Skin problems
❑ Congestive heart failure	❑ HIV / AIDS	❑ Stomach ulcers
❑ Depression	❑ High blood pressure	❑ Thyroid Problems
❑ Diabetes (Type I or II)	❑ High cholesterol	❑ Other _____

Do you currently smoke? ❑Yes ❑No If yes, how many packs per day? _____

Do you prefer NON-SAFETY CAPS for your prescription bottles? ❑Yes ❑No

I understand the importance& agree to notify the pharmacy if any of the above information changes ❑Yes ❑No

Signature: _____ **Date:** _____

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Please list the medications you are currently taking:

Pharmacy Name: _____Phone #_____ ***Physician and phone #_____*** ***Rx # Medication name Strength/ Directions***	***Today's Date: _____*** ***List quantity remaining***	***Time(s) of day meds taken AM, NOON, PM, Bedtime***
RX #		
RX #		
RX #		
RX #		
RX #		
RX #		
RX #		
RX #		
RX #		
RX #		

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