**SYNC RX**

**PATIENT ENROLLMENT FORM**





**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. Advantagesof 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 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 co­pay *one time* for each medication in order to make all refills due on the same day.
* To accept a monthly phone call from Pharmacist to discuss my chronic prescription refills.

**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.***Please select your packaging option below:

❏30 day**-multi-dose Dispill packaging (recommended)**

❏30 day**-individual bubble packs**

❏30 day**-Bottles** **Do you prefer NON-SAFETY CAPS for your prescription bottles? ❏Yes ❏No**Select the method in which you would like to receive your prescriptions:

❏**Pickup**

❏**Delivery (if you are outside of our delivery zone, we will UPS your medications to you--- *credit card required for payment*)**

**Do you require a MAR? (please circle): Yes** or **No
Do you have any other special needs? (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or caregiver signature Date

|  |  |
| --- | --- |
| **New PatientInformation Form** *Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  | *Date of Birth \_\_\_\_ /\_\_\_\_ /\_\_\_\_  mm dd yy*  |
|  *First MI Last Name* |  |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone : \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ ❏ I give my consent to contact regarding my prescriptions/payments |
| Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| * **\*\*\*\*\* Drug Allergies**❏ no ❏ yes **List drugs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 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 (required for UPS) ❏Check |
| **Please check the following health conditions you have** |
| ❏ Acid Reflux (GERD)❏ Anxiety❏ Arthritis❏ Asthma❏ Bipolar disorder❏ Cancer❏ Chest pain (Angina)❏ COPD❏ Congestive heart failure❏ Depression❏ Diabetes (Type I or II) | ❏ Kidney disease❏ Emphysema❏ Glaucoma❏ Hardening of arteries❏ Headaches❏ Hypothyroid❏ Hyperthyroid❏ Irregular heart beat (Arrhythmia)❏ HIV / AIDS❏ High blood pressure❏ High cholesterol | ❏ Liver disease❏ Parkinson’s disease❏ Previous heart attack❏ Previous stroke❏ Schizophrenia❏ Seizures❏ Sexual dysfunction❏ Skin problems❏ Stomach ulcers❏ Thyroid Problems❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you currently smoke?❏Yes ❏No If yes, how many packs per day? \_\_\_\_\_\_\_\_\_ |
|  |
| **I understand the importance & agree to notify the pharmacy if any of the above information changes ❏Yes ❏No**  |
| **Si Patient or caregiver signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Please list the daily medications you would like to be filled monthly below:**Todays date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| ***Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** ***Physician and phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rx # Medication name Strength/ Directions*** | ***List quantity of tablets/capsules remaining in your bottle currently (This is very important to sync your meds)*** | ***List time(s) of day meds are taken******AM, NOON, PM, Bedtime*** |
| RX #  |  |  |
| *RX #* |  |  |
| *RX #* |  |  |
| *RX #* |  |  |
| *RX #* |  |  |
| *RX #* |  |  |
| *RX #* |  |  |
| *RX #* |  |  |
| *RX #* |  |  |

**Please list medications you do not take daily. We will check with you on your monthly call to see if you need them included in your monthly order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**