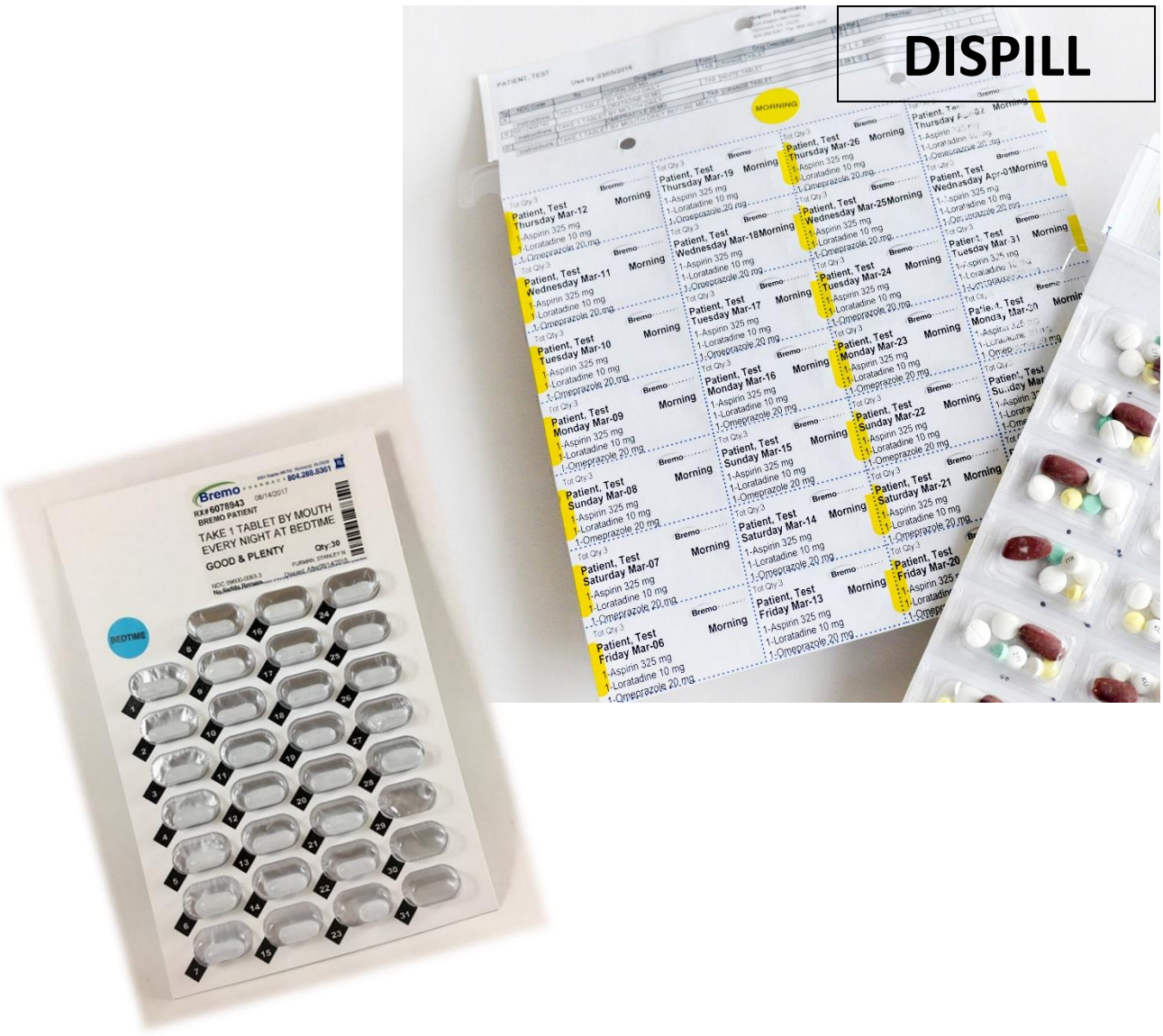
Small Pharmacy... Big Hearts
www.BremoRX.com
2024 Staples Mill Road Richmond, VA 23230
*Tel* 804.288.8361 / *Fax* 804.355.1639
For secure email options please visit **BremoRX.com/** contact

# 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.*

Bremo PHARMACY

Small Pharmacy... Big Hearts
www.BremoRX.com

2024 Staples Mill Road Richmond, VA 23230
*Tel* 804.288.8361 / *Fax* 804.355.1639
For secure email options please visit **BremoRX.com/** contact

# Pharmacy Copy, please read and sign

## Agreement to Participate in SyncRx, Bremo's 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 FREE 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.
- Pocket Medication lists available
- Benefits offered: waived packaging fees, waived delivery fees, waived medication disposal fee.

**I understand the program's 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 co-pay *one time* for each medication in order to make all refills due on the same day.
- To have a credit card on file as payment for prescription copays and OTC purchases.
- To accept a monthly phone call from pharmacist to discuss prescription refills.

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

Please select your packaging option below:

❑30 day**-multi-dose Dispill bubble packaging (recommended)**
❑30 day**-individual calendar cards**
❑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**
❑ **FREE Delivery (if you are outside of our delivery zone, we will UPS your medications to you)**

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

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

_____
Patient name (please print)

_____ _____
Patient or caregiver signature Date

*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.*

Small Pharmacy... Big Hearts
www.BremoRX.com
Bremo PHARMACY
2024 Staples Mill Road Richmond, VA 23230
Tel 804.288.8361 / Fax 804.355.1639
For secure email options please visit BremoRX.com/ contact

# 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: _____ Relationship :_____

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

Primary Care Physician _____

➔ ***** **Drug Allergies**❑ no ❑ yes **Severity:** ❑Mild ❑Moderate ❑Severe

➔ **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: _____

**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**

**Patient or caregiver signature:** _____

**Date:** _____

*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.*

Bremo PHARMACY

Small Pharmacy... Big Hearts
www.BremoRX.com
2024 Staples Mill Road Richmond, VA 23230
*Tel* 804.288.8361 / *Fax* 804.355.1639
For secure email options please visit **BremoRX.com/** contact

**Please list the <u>daily</u> medications you would like to be filled monthly below:**

Todays date: _____

| ***Pharmacy Name:*** _____***Phone #***_____<br>***Physician and phone #***_____<br><br>***Rx # Medication name Strength/ Directions*** | ***List quantity of tablets/capsules remaining in your bottle currently (This is very <u>important</u> 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:**

_____

_____

_____

*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.*