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

SYNC RX

PATIENT ENROLLMENT FORM

Large Capacity up to 16 Unique Meds.

The C.A.R.E. Package

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 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 Medicine-On-Time Packaging (recommended)**

❑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

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New Patient Information Form

Date of Birth ____ /____ /____
mm dd yy

Name ________________ ___ ________________
First MI Last Name

SSN ____________________________ ❑Male ❑Female

Address ________________________________ ________________ __ __________
Street City State Zip Code

This address is a facility: ❑ Yes ❑ No

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)	❑ 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? _________

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

Patient or caregiver signature: ______________________________ **Date:** ________________

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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:

____

____

____

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