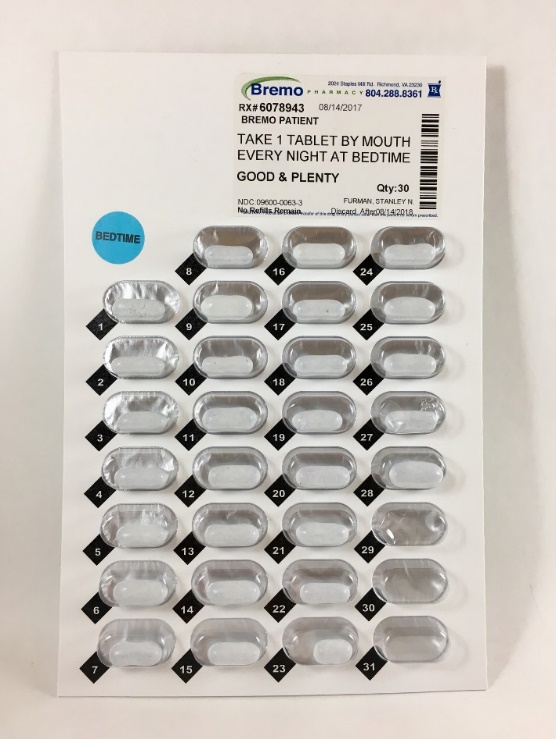
**SYNC RX**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**