HARBORVIEW MEDICAL CENTER
UW Medicine | King County
Long-Term Care Pharmacy

managed by
KELLEY-ROSS PHARMACY GROUP

2324 Eastlake Ave. E #400a, Seattle, WA 98102
P: 206.838.4590 F: 206.838.4599

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ MI: ____

Full Name on Insurance (if different): _____

Date of Birth: _____ SSN: _____-_____-_____ Sex: ____ Gender: _____ Pronouns: _____

Mailing Address:_____ City:_____ State:____ Zip Code:_____

Chronic Medical Conditions: _____

_____

Allergies:_____ ☐ No Known Drug Allergies

Medication Information:

Medication Name:	Dosage:	Frequency:	Reason Taken:

Facility Information

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

_____ E-Mail: _____

Owner/Contact Name: _____ Other Phone Number: _____

Physician Info

Primary Physician Name: _____

Physician Phone #: _____ Fax #: _____

Address: _____

Pharmacy Info

Previous Pharmacy: _____

Pharmacy Phone #: _____ Fax #: _____

Address: _____

*From multiple phsysicans or pharmcies please attach a list.

Insurance Information:

Primary Insurance Name:_____

Policy ID: _____

RxGroup#: _____ Bin#: _____ PCN: _____

Secondary Insurance Name:_____

Policy ID: _____

RxGroup#: _____ Bin#: _____ PCN: _____

Medicaid #: _____Medicare #: _____

Alternatively, attach copies of front and back of all insurance cards.

Discharge Info

Resident Discharging From:

☐ Hospital
☐ SNF / ALF
☐ AFH
☐ Patient's Own Residence

Discharge Facility Name:

_____

_____

Phone #:_____

Does patient have medications on hand for use: ☐ Yes ☐ No

How many days supply? _____

Expected Arrival at New Facility

Date:_____

Time: _____

For Internal Use:

Date Received:_____ Delivery Date:_____

Packaging: ☐ Bingo ☐ PacMed ☐ Synmed☐ Bottles

Cycle: ☐ Yes ☐ No Cycle Length: _____

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PHARMACY SERVICES PROVIDER AGREEMENT

Patient Name:_____ Agency/Facility Name:_____

I, _____ authorize Harborview Long Term Care Pharmacy (referred to in this agreement as the "Pharmacy") to provide medications and associated products and services to the above-named patient. I certify that I have the legal authority to sign this agreement on behalf of said patient and I understand that by signing this agreement I will become responsible to pay the usual and customary fee for all medications, products, and services provided tothe patient by the Pharmacy at the direction of the facility administration and staff and attending physician(s). If I disagree with any medication, product or service directed by the facility or an attending physician, I will contact them and resolve the issue(s) and ask them to provide different written direction to the Pharmacy. I acknowledge and agree that the Pharmacy provides medications, products or services based upon the most current written direction received by it.

For patients receiving benefits from an insurance company (referred to in this agreement as a Pharmacy Benefits Manager "PBM"), I am aware that the Pharmacy will bill the PBM for all medications, products and services covered by the PBM and that I am responsible for any co-payments that may apply and/or for the payment for all medications, products and services provided by the Pharmacy that are not covered by the PBM. Should I arrange for home health and/or hospice services and supplies, I understand that Medicare will not reimburse me or my supplier and I will be responsible for their cost as well.

In addition, I also understand that the medications furnished to the above-named resident are not packaged in child-proof containers. I agree that the facility personnel are authorized to order purchases and charges on behalf of the above-named resident. I agree to pay all charges incurred by the above-named resident that are not paid for by third party payers, including Medicare and Medicaid. I understand that medications that are delivered to the above-named facility and subsequently discontinued or modified by the above-named resident's physician or otherwise not used by the above-named resident for any reason cannot be returned for credit. I understand that all medications, once delivered are not returnable per WAC 246-869-130, and I will be responsible for the full amount due. I understand that statements printed at the beginning of the month are for medications sent the previous month, therefore should the above-named resident move out the above-named facility or pass away I am still obligated to pay the final balance by the end of the statement month. I agree to pay the entire amount due by the end of the statement month unless prior arrangements were made with the Pharmacy's billing department. I understand that if no payment or partial payment were received for the previous month, the Pharmacy may reserve the rights to refuse services for the above-named resident. If your account becomes 120 or more days delinquent, the Pharmacy may reserve the rights to send your account to collection. I agree to pay all costs of collection, including court costs and attorney fees, for all delinquent balances. I agree to pay the Pharmacy a fee of $40.00 per RCW 62A.3-515 (b)(1) if for any reason a check issued for the above-named resident is not honored by the financial institution. The Pharmacy does not accept postdated checks.

Assignment of Benefits

I hereby request that payment of authorized insurance benefits be made on the patient's or my behalf to the Pharmacy for medications, products and/or services furnished to the patient. I authorize the Pharmacy to release any necessary or required personal health information to the Center for Medicare and Medicaid Services, any health insurance company, and/or their agents for the purpose of determining benefits or resolving any question regarding.

Signature:_____ Date: _____

(By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.)

Responsible Party Name: _____Relationship: _____

Billing Address:_____ City:_____ State:____ Zip Code:_____

Phone Number: _____E-Mail: _____

Please check all that apply: ☐ **Medical Decisionmaker** ☐ **Financial Payee** ☐ **Both** ☐ **Patient is Self-POA/Payee**

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RESIDENT/RESPONSIBLE PARTY AGREEMENT

Patient Information

Last Name: _____ First Name: _____ MI: ____
Full Name on Insurance (if different): _____
Date of Birth: _____ Gender: _____ Sex Assigned at Birth: _____Pronouns: _____
Mailing Address:_____ City:_____ State:____ Zip Code:_____

Responsible Party

Please write "Self" for relationship if the patient is also the Responsible Party.

Responsible Party Name: _____Relationship: _____
Billing Address:_____ City:_____ State:____ Zip Code:_____
Phone Number: _____E-Mail: _____

Please send statements to: ☐ Mailing Address ☐ Billing Address ☐ Other:_____

Payment Information

Card Number: _____ Card Exp: _____
Name of cardholder: _____ Security Code (cvv): _____
Billing Address:_____ City:_____ State:____ Zip Code:_____
☐ Please automatically charge the above card once monthly on the _____ day of the month.

I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:

- I agree that facility personnel are authorized to order purchases and charges on behalf of the above-named resident.
- I agree to pay all charges incurred by the above-named resident that are not paid for by third party payors, including Medicaid, and additional charges for specially packaged medications.
- I will pay the entire amount due within 30 days of the statement date shown on the monthly billing statement and understand that a 1.5% late charge will be added to the balance owed for delinquency of 30 days or more.
- I agree that in order for the resident's account to remain active, payment for billed charges must be made promptly pursuant to these terms.
- I agree to pay all costs of collection, including court costs and attorney's fees, for all delinquent balances.
- I understand that the medications furnished to the above-named resident are not packaged in child-proof containers.

I consent to the release of personal and medical information to any third-party payor, governmental agency providing benefits, or other person/entity liable for my treatment charges. In addition, I consent to a similar release of information, as shall be necessary, to initiate and continue my use of pharmacy, laboratory, or other community resources, and/or for transfer to another health care facility.

Signature:_____ Date: _____

(By signing, I acknowledge that I have read and understand the terms and conditions of this Resident/Responsible Party Agreement.)