1412 SW 43rd St, Renton, WA 98057
Phone (425) 251-6335 Fax (425) 988-1319
www.ReadyMedsPharmacy.com

**Internal Use:**
Facility Code: ___________________
Received Date: _________________
Delivery Date: __________________
PACKAGING:
☐ Bingo ☐ Multi-Pack ☐ Dispill ☐ HOA

# NEW CLIENT FORM

***** Please complete and fax this form with a copy of medication list or discharge order. Without this we cannot send medication. *****

## FACILITY INFORMATION:

Date: ______________________

Name: ______________________________________________ Phone Number: ______________________

Address: ______________________________________________ Fax Number: ______________________

Owner Name: ______________________________________________ Client Admit Date: ______________________

## NEW CLIENT INFORMATION:

Last Name: ________________________________ MI: ________ First Name: ______________________

Date of Birth: ______________________ SSN: ______________________ Gender: ☐ M ☐ F

Chronic conditions: ____________________________________________________________

____________________________________________________________

Allergies: ____________________________________________________________

## RESPONSIBLE PARTY INFORMATION FOR BILLING: ***if no payee or Self POA, Credit Card is required***

Full name: ________________________________ Relationship to Client: ______________________

Billing address: ________________________________ City: ____________________ State: ________ Zip Code: ____________

Home Phone #: ____________________ Cell phone #: ____________________

## MEDICAL INFORMATION:

Primary Physician Name: ________________________________ Phone # ____________________ Fax # ____________________

Specialist/Physician Name: ________________________________ Phone # ____________________ Fax # ____________________

Previous pharmacy: ______________________________________________ Pharmacy phone # ____________________

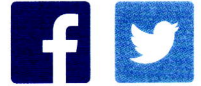
## PRESCRIPTION INSURANCE INFORMATION:

Primary Insurance Company: ____________________________________________________________

Policy ID #: ______________________ Group#: __________________ BIN #: __________________ PCN: __________________

Medicaid DSHS/ Provider One Card #: ________________________________ Medicare Part B #: ______________________

Thank you for using Ready Meds Pharmacy, "Home of your Personal Pharmacist."



1412 SW 43rd Street Ste 120 • Renton, WA 98057
(P) 425-251-6335 • (P) 877-425-MEDS • (F) 425-251-6337
www.ReadyMedsPharmacy.com

Ready Meds Pharmacy
1412 SW 43rd street Suite 120
Renton, WA 98057
Phone: (425) 251-6335
Fax: (425) 251-6337
readymedspharmacy@gmail.com

**Re: Resident Payment Guarantee and Financial Agreement Form**

**Resident's Name:** ______________________________

**Date of Birth:** ______________________________

**Facility's Name:** ______________________________

**I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS AND CONDITIONS:**

- 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 the statements printed at the beginning of the month are for medications sent the previous month, therefore should the above-named resident moved out the above-named facility or passed away I may still receive one additional statement the following month due to any overlapping charges. I understand I am still obligated to pay the final balance within 30 days of receiving this final statement.
- I agree to pay the entire amount due within 30 days of the statement date unless prior arrangements were made with Ready Meds Pharmacy's billing department. Statements are printed on the 1st business day of each month and mailed out on the 2nd.
- If full payments are not received by the end of the month, I agree to pay a finance charge of 2.00% per month or a minimum service charge of $5.00 whichever is greater on the leftover balance.
- I understand that if no payment or partial payment were received for the previous month, Ready Meds Pharmacy may reserve the rights to refuse services for the above-named resident.
- If your account becomes 120 or more days delinquent, Ready Meds 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. There will be a collection fee of 50% of the final balance upon closing of the account.
- I understand that the medications furnished to the above-named resident are not packaged in child-proof containers.

______________________________ ______________
SIGNATURE OF RESPONSBILE PARTY OR PAYEE DATE

______________________________ ______________
PRINT NAME OF RESPONSBILE PARTY OR PAYEE PHONE #

______________________________ ______________
ADDRESS OF RESPONSBILE PARTY OR PAYEE CITY, STATE, ZIP CODE

* * * * * Please return completed form to Ready Meds Pharmacy within 7 days of moving in * * * * *

1412 SW 43rd St. • Suite 120 • Renton, WA 98057

P 425-251-6335
F 425-251-6337

www.readymedspharmacy.com

# Credit Card Authorization Form

| **Card Type:** | **Visa/MasterCard/AMEX/Discover** |
|---|---|
| **Name on Card:** | |
| **Billing Address** | |
| **City/State** | |
| **Zip Code:** | |
| **Card Number:** | |
| **Expiration Date:** | |
| **Security Code:** (CVV- from back of card.) | |
| **Patient's Name:** | |
| **Patient's DOB:** | |
| **Name of Assisted Living Facility:** | |

I_________________________________, authorize Ready Meds Pharmacy, Inc to charge automatically to my credit and/or debit card outlined above monthly for payments owed on the monthly statement for the client above. I understand that I will continue to receive a monthly statement for my information and review.

I acknowledge that Ready Meds Pharmacy will be storing my credit card information on a secure server for billing purposes only.

I understand that to cancel this arrangement, I will have to contact Ready Meds Pharmacy in writing directly.

Cardholder Signature: _____________________________________ Date: ______________________

*Please contact a representative in our Billing Office with any questions at* (425) 251-6335.

Washington State Health Care Authority

# Agreement to Pay for Healthcare Services

WAC 182-502-0160 (“Billing a Client”)

This is an agreement between a “client” and a “provider,” as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, “services” include but are not limited to healthcare treatment, equipment, supplies, and medications

**Client -** A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.
**Provider** - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

| Client’s printed name | Client’s ID number |
|---|---|
| Provider’s printed name | Provider number |

**Directions:**

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- **The provider and the client must complete this form only *after* they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.**
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

**Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.**

**Important Note from HCA:**

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client’s medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at http://hrsa.dshs.wa.gov/mpforms.shtml.

| Specific service(s) or item(s) to be provided and anticipated date of service | CPT/CDT/ hcpc code (billing code) | Amount to be paid by client | Reason why the client is agreeing to be billed (check the one that applies for each service) | Covered treatment alternatives offered but not chosen by client | Date(s) etr/nfj requested/denied or waived, or prior authorization (pa) requested/denied, if applicable | |
|---|---|---|---|---|---|---|
| | | | ☐ Noncovered service, ETR denied<br>☐ Noncovered service, ETR waived<br>☐ Covered but denied as not medically necessary<br>☐ Covered, but specific type not paid for<br>☐ Order, prescribed, or referred by non-enrolled licensed health care professional | | ETR requested or waived | ETR denial (attach HCA notice) |
| | | | | | PA request | PA denial (attach HCA notice) |
| | | | ☐ Noncovered service, ETR denied<br>☐ Noncovered service, ETR waived<br>☐ Covered but denied as not medically necessary<br>☐ Covered, but specific type not paid for<br>☐ Order, prescribed, or referred by non-enrolled licensed health care professional | | ETR requested or waived | ETR denial (attach hca notice) |
| | | | | | PA request | PA denial (attach HCA notice) |
| | | | ☐ Noncovered service, ETR denied<br>☐ Noncovered service, ETR waived<br>☐ Covered but denied as not medically necessary<br>☐ Covered, but specific type not paid for<br>☐ Order, prescribed, or referred by non-enrolled licensed health care professional | | ETR requested or waived | ETR denial (attach HCA notice) |
| | | | | | PA request | PA denial (attach HCA notice) |

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; or 2) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- ***I agree to pay the provider directly for the specific service(s) listed above***.
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

| | | |
|---|---|---|
| **I AFFIRM: I understand and agree with this form's content, including the bullet points above.** | Client's or client's legal representative's signature | Date |
| **I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.** | Provider of service(s) signature | Date |
| **I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.** | Interpreter's printed name and signature | Date |