MetMeds Pharmacy

Please complete and sign each of the following forms:

Client/Health Information:

Full Name: ____________________

Address: ____________________ Apt No.: __________

City: ____________________ State: **Washington** Zip: __________County: __________

Social Security No.: _______-_______-_______ Date of Birth: ____/____/______ Male ☐ Female ☐

Home Phone: ______________ Cell Phone: ______________ Best time to call: __________

Name of Primary Insurance: ____________________ ID No.: __________

Group No.: ______________ PCN: ______________ BIN: __________

Name of Secondary Insurance: ____________________ ID No.: __________

Group No.: ______________ PCN: ______________ BIN: __________

Preference when MetMeds is calling you:

☐ Identify Pharmacy **(or)** ☐ **Do Not** Identify Pharmacy ☐ Leave Message **(or)** ☐ **Do Not** Leave Message

By what date will you need your next medications (based on current supply of medications you have): ____/____/______

Please list all medications you currently take (include all prescriptions, OTC, herbal/dietary supplements, vitamins/minerals:

____

____

____

____

____

Drug Allergies: ☐ None ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Penicillin ☐ Sulfa ☐ Other __________

Chronic health conditions (e.g. diabetes, high blood pressure): ____________________

____

Note: State law allows the substitution of generically equivalent drugs for certain brand name drugs **unless otherwise noted by your physician**. Consult your doctor if you feel this could be a concern.

Doctor Information:

Doctor Name: ____________________ Hospital/Clinic: ____________________

Street Address: ____________________ Suite No.: __________

City: ____________________ State: __________ Zip: __________

Phone: ______________ Fax: ______________ Email: ______________

Current Pharmacy Information:

Pharmacy Name: ____________________ Phone No.: __________

Client/Authorized Signature: ____________________ Date: ____/____/______

If needed, please attach additional documentation describing information asked for on this form

MetMeds Pharmacy

Note: The MetMeds MetPacks sent to our clients are **NOT child-resistant containers** and for this reason requires that we receive from all new clients a signed statement acknowledging that they understand and accept this **NON child-resistant packaging**. Additionally, MetPacks are sent to our clients in both unit-dose and multi-dose packets. This also requires that we receive from all new clients a signed statement acknowledging that they understand and accept that they will be receiving a substantial, if not all, of their medications in **packets that contain multiple medications**. **Please read and sign all of the following forms:**

Acceptance of NON Child-Resistant Medications Containers:

I ________________________________ the undersigned, understand and accept that the MetMeds MetPacks medications
Print Name

packaging that I will be receiving are **NOT child-resistant containers** and that in signing this form I am acknowledging and accepting receipt of my medications in these **NON child-resistant MetPacks medications packets.**

Client/Authorized Signature: ____ Date: ____/____/______

Acceptance of MetPacks that Contain Multiple Medications in Each Packet:

I ______________________________ the undersigned, understand and accept that the MetMeds Multi- Dose MetPacks
Print Name

medications packaging that I will be receiving **contain multiple medications in each packet** and that in signing this form I am acknowledging and accepting receipt of my medications in these **multi-dose MetPacks medications packets.**

Client/Authorized Signature: ____ Date: ____/____/______

Acknowledging receipt of a copy of the MetMeds - Pharmacy NOTICE OF PRIVACY PRACTICES as required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996:

I ______________________________ the undersigned, acknowledge that I have received a copy of the MetMeds - Pharmacy
Print Name

NOTICE OF PRIVACY PRACTICES document outlining the MetMeds practices in complying with the Health Insurance Portability & Accountability Act (**HIPAA**).

Client/Authorized Signature: ____ Date: ____/____/______

Acknowledging receipt of medications and authorizing release of insurance information:

I _____________________________ the undersigned, understand that by electing to have my medications delivered I will be
Print Name

receiving these medications via a signature courier and that signing for or allowing a representative to sign for the medications packages from the courier is; acknowledging receipt of all expected medications and associated documentation that includes the following: Date, Rx Number, Third-Party Program (insurer), Phone number for available pharmacy counseling (**1-800-835-1501**), as well as the below statements:

PHARMACY:
Please have the patient, guardian, or legal representative who has received the medications package and associated documentation read this statement before signing for the medications package and its associated documentation.

PATIENT:
Your signature on the couriers receipt acknowledgment form certifies that the medications contained in the medications package and its associated documentation is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medications identified in your medications package and its associated documentation and authorize release of all the information contained in the medications package and its associated documentation and the prescriptions to which the documentation corresponds to the plan administrator, the underwriter, the sponsor, the policy holder, the insurer, the employer, and their authorized agents. You further certify that this medication is not for treatment of an on-the-job injury, and you hereby assign to this provider pharmacy any payment due pursuant to this transaction, and authorize payment directly to this provider pharmacy.

FOR MEDICAID RECIPIENTS ONLY:
Your signature certifies that you received a service or item dispensed on the date listed in your medications package and its associated documentation. You understand that payment for this service or item will be from Federal and State funds and that any false claims, statements, or documents or concealment of material facts may be prosecuted under applicable Federal and State Laws.

I the undersigned have read all of the above and authorize the release of any and all information supporting the receipt of the medications claim to my insurance company.

Client/Authorized Signature: ____ Date: ____/____/______

____

MetMeds Pharmacists will sign below:

I certify that the prescriptions referred to herein were or will be lawfully dispensed to the person whose signature appears above and the prescriptions comply with the conditions and applicable instructions of the third party program identified. I also certify that the information covering each transaction is, to the best of my knowledge, correct and that all documentation is available for audit.

Pharmacist's Signature: ____ Date: ____/____/______

MetMeds Pharmacy: 5707 Lacey Blvd. SE, Suite 103 Lacey, WA 98503-2496

Pharmacy toll free phone: 1-800-835-1501 - or local: 360-459-5401

Please mail completed forms to MetMeds at: 5707 Lacey Blvd. SE, Suite: 103 Lacey WA 98503-2496
For additional information or help getting started call toll free 1-800-835-1501 - or - local: 360-459-5401