Reliable RX Intake Form

Phone: (513) 809-1122
Email: reliablerx513@gmail.com

Reliable Rx
AGING IN PLACE

PATIENT INFORMATION (PLEASE PRINT)

Patient Last name: | First | Middle:

Sex: ☐ Male ☐ Female ☐ Unidentified

Birth Date: / /

Street Address:

Social Security:

City: | State: | Zip Code:

Allergies: (check all that apply) ☐ No Known Drug Allergies ☐ Codeine ☐ Erythromycin ☐ Aspirin ☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Other (Please specify)

Phone:

Facility Name:

Cell:

Email:

Diagnoses:

GUARDIAN INFORMATION

Name:

Street Address: | Phone:

City: | State: | Zip Code: | Cell:

PRIMARY INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes (Please send a copy, front and back, of the patients insurance card(s)) ☐ No (skip section)

Cardholders Name: | Insurance Company:

BIN# | PCN# | ID# | Group#

PAYEE INFORMATION

Responsible Party/Caregiver's name who is in charge of patient's finances:

Address: | Phone Number:

City: | State: | Zip Code: | Fax Number:

CREDIT CARD INFORMATION

Credit Card Number: | Card Type: | Expiration Date:

Name On Card: | Address:

City: | State: | Zip Code: | Security Code:

MEDICATIONS/MEDICAL SUPPLIES DELIVERY INFORMATION

Address for deliveries: ☐ Home (Address listed under patient information)

☐ Office
Street Address:
City: State: Zip Code:

☐ Other
Street Address:
City: State: Zip Code:

Do we have permission to leave the package if someone is not there to sign for it? ☐ Yes ☐ No
If yes, please fill out and return the form on page 4

Patient/individual may sign for any medication deliveries: ☐ Yes ☐ No

Medication Administration Records (MARs): ☐ Needed ☐ Not Needed

MEDICATION SPECIAL PACKAGING & START DATE

Package Type: ☐ Blister Cards ☐ Vials ☐ Multidose

Start date for medications/supplies:

DAY PROGRAM OR SCHOOL/WORK

Which one does the patient attend?
☐ None ☐ Day program ☐ Work
☐ School ☐ Other:

Days & times attending:

PRIMARY TO CONTACT FOR TRANSFERS

Name:

Street Address: Phone:

City: State: Zip Code: Cell:

ACKNOWLEDGMENTS AND RESPONSIBILITIES

initials — I have received a copy of Reliable Rx Notice of Privacy Practices. Federal regulations require that we obtain proof that our customers have received the Notice of Privacy Practice

initials — The Reliable Rx packaging is NOT child resistant. By initialing, you indicate that you are requesting that all medications shall be dispensed in “non-childproof” packaging.

initials — I understand that due to the purchase of patient specific medications in advance of your needs to assure all medications are in place each month, a 90 day written notice must be given to Reliable RX before transferring to the pharmacy of your choice.

RESPONSIBLE PARTY/CAREGIVER INFORMATION	
Responsible Party/Caregiver is an individual who assists with healthcare decisions	
Responsible Party/Caregiver's name:	Phone Number (work):
Relationship to patient:	Phone Number (cell):

The above information is true to the best of my knowledge. I authorize this patient's insurance benefits to be paid directly to Reliable Rx. I understand that the payee is financially responsible for any balance. I also authorize Reliable Rx or insurance company to release any information required to process my claim.

Responsible Party/Caregiver's name:

Medication Information (Please fill out below or provide copy of MARs or POs)

Prescription #:	Medication Name & Strength:	
Directions:		
Start Date:	Administration Times:	Diagnosis:
Physician's Name:	Phone #:	Fax #:
Pharmacy Name:	Phone #:	Fax #:

Prescription #:	Medication Name & Strength:	
Directions:		
Start Date:	Administration Times:	Diagnosis:
Physician's Name:	Phone #:	Fax #:
Pharmacy Name:	Phone #:	Fax #:

Prescription #:	Medication Name & Strength:	
Directions:		
Start Date:	Administration Times:	Diagnosis:
Physician's Name:	Phone #:	Fax #:
Pharmacy Name:	Phone #:	Fax #:

Prescription #:	Medication Name & Strength:	
Directions:		
Start Date:	Administration Times:	Diagnosis:
Physician's Name:	Phone #:	Fax #:
Pharmacy Name:	Phone #:	Fax #:

Permissions to Leave Medications/Supplies
No Signature Required

I _____ give Reliable Rx permission to leave medications/supplies, if no one is home for
Name

_____ at _____ I understand that I take full responsibility and
Patient Name Address

Reliable Rx will not replace any lost, stolen, damaged, etc. products.

Choose one:

☐ Permissions to Leave Location (ex. porch, back door, etc.) _____

☐ Key Lock Box (Requires entry to home) (ex. right inside door, kitchen table, etc.) _____

Patient of Caregiver Signature _____

Patient of Caregiver Print _____

Contact Phone Number _____

Date _____