INTAKE FORM

Community: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

Resident Name: _____ Date of Birth: _____ Gender: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Diagnosis: _____

Allergies: _____

Social Security Number: _____ Medicare Number: _____

Primary Insurance: _____ Customer Service Number: _____

ID# _____ Bin# _____ Grp# _____ PCN# _____

Secondary Insurance: _____ Customer Service Number: _____

ID# _____ Bin# _____ Grp# _____ PCN# _____

****(Copy of front and back of ALL insurance cards is required) ****

- ❑ New to Lincoln Pharmacy – Community I live at or moving into: _____ Planned MOVE DATE:
- ❑ Transitioning from hospital- Please specify which one: _____ Planned MOVE DATE:
- ❑ Transitioning from rehab- Please specify which one: _____ Planned MOVE DATE:
- ❑ Transitioning from home. Previous Pharmacy: _____ Planned MOVE DATE:

RESPONSIBLE PARTY: _____ RELATION: _____

BILLING ADDRESS: _____

PHONE: _____ EMAIL: _____

BILL CREDIT CARD (___ ONE TIME ___ MONTHLY) TYPE OF CARD: ____ VISA __ MC __ AMERICAN EXPRESS ___ DISOVER CARD

CREDIT CARD NUMBER: _____ EXP. DATE: _____ SECURITY CODE: _____

Lincoln Pharmacy works in conjunction with the community to ensure the management of medications, orders, refills and supplies are completed in a safe and orderly fashion. As the Responsible party I understand that Lincoln Pharmacy is obligated to abide by any requests put forth in order to maintain health and safety of the resident. At which point the regular process would be communicated to the community's staff. I understand that I am financially responsible to Lincoln Pharmacy for all charges incurred for the named resident. If the resident has Medicaid, all non-covered OTC and supplies will be billed to the resident, unless prohibited by regulations. I understand that I am responsible for payment of any medications or other charges for the resident not covered by third party insurance while he/she resides in the community. I understand that Lincoln Pharmacy will attempt to bill insurance for all medications, equipment and supplies provided to the named resident. I agree to assume responsibility for paying all charges incurred.

Statement balances will be mailed at month end. It is understood that the bill will be paid in full, or payment arrangement will be made with Lincoln Pharmacy. If no payment is received be advised that the pharmacy may suspend services at any time. As a courtesy we will make an attempt to communicate either directly with the party responsible or through community staff. I hereby authorize any holder of medical and/or insurance information about the named resident to disclose such information to Lincoln Pharmacy. I further authorize Lincoln Pharmacy to disclose any medical and/or insurance information concerning the named resident in its possession to other professional personnel involved in patient care such as physicians, nurses or other such personnel. Any disclosure will be made in compliance with HIPAA guidelines and other state and federal regulations.

I request currently Lincoln Pharmacy Provide: (please initial all that apply)

*Please note that any medications supplied are not in child proof packaging unless requested.

_____ All Medications/PRN Medications (to include OTC/copays)

_____ Requested Medications ONLY

_____ Diabetic Supplies as requested

_____ Incontinent Supplies as requested

_____ Equipment as requested

Resident Signature: _____ Printed Name: _____ Date: _____

Responsible Party: _____ Printed Name: _____ Date: _____

LINCOLN PHARMACY 821 S. 38th Street Tacoma, WA 98418 PH: 253-473-1155 FX: 253-473-1158

EMAIL: slawson@lincolnrx.com