Hoagland Pharmacy—Retail
2330 Yew Street
Bellingham, WA 98229
Mediset Dept Direct phone number: (360) 685-5014
Fax number: (360)734-7547

Medication Compliance Program Specifications

The Hoagland Pharmacy Medication Compliance program is designed to provide a medication management system for people who require minimal supervision but have some trouble keeping track of their medications. Prescriptions are filled and kept at the pharmacy, then dispensed in weekly Dispill containers. The goal is to minimize the number of prescription bottles at home in order to reduce confusion, stress, and possible misuse of medication. The containers are assembled by Pharmacy Technicians and then double checked by a Pharmacist to ensure safety and accuracy.

In order to provide the best care, it is absolutely vital that the patient or caregiver notifies us of the names of the primary care provider and any specialist being seen (i.e. Cardiologist, Neurologist). It is also essential *that all prescriptions are filled at Hoagland Pharmacy*. Even if the medication does not go into the mediset, **all orders must be on the patient record in order for the pharmacy to detect drug interactions**. This includes vitamins and supplements. The exception is when the patient is seen at an urgent care clinic or emergency room after Hoagland Pharmacy hours of operation. However, we do need to be made aware of what was prescribed.

If at any point it becomes apparent to our staff that program services are no longer sufficient to ensure safe medication administration, we reserve the right to deny further services and recommend that more/other assistance be provided.

Delivery: Hoagland Pharmacy has delivery services available for customers who are unable to drive or lack means of transportation. Deliveries are made once weekly on the same day and the fee is included in our monthly fee. If for any reason, the patient misses the delivery, we can either have the mediset ready to be picked up at the store or re-deliver. It will cost $7 for a re-delivery.

Pick-up: Customers, who want to pick-up or are out of our delivery range, can choose to pick up weekly, bi-weekly, or monthly. Pick-ups need to be made on a strict rotating schedule, so that we can plan and prioritize their work effectively. This means that if the first cycle is picked up on Monday, the department assumes that the next set needs to be ready by the following Monday.

Fees: The monthly fee for the Medication Compliance program is $30 which may be covered by Medicaid only if patient qualifies. This fee does not include co-pays, over the counter items requested by the patient, or prescriptions that are not covered by insurance. When starting the program there is also a onetime set-up fee of $30. This fee is not covered by any insurance.

Insurance: It is the patient's responsibility to provide the pharmacy with all current insurance information and notify the pharmacy of any changes in coverage. We will call ahead of time if prescriptions are not covered by the insurance and it will be up to the patient to decide whether to pay the cash price or contact their Physician for an alternative.

Insurances often require prior authorizations for certain medications. This means that the insurance has certain criteria that must be met in order for the medication to be covered. This process can take anywhere from a few days to two weeks. When this process is started, the physician is notified via fax.

Vacations: If the patient needs extra medication because of an upcoming vacation, we ask to be notified as far in advance as possible (a minimum of two weeks) so that we can plan ahead and have time to work with the insurance company if necessary.

Left-over medications: We understand that even with our services, sometimes doses of medications get missed. If disposal of unused medications is needed, we have a disposal bin in our store where you can safely drop off your unused medications. Please keep in mind; the regulations of the bin prohibit Hoagland staff from handling these unused medications.

Please fill out this page and return to pharmacy as soon as possible to begin services. Thank you.

Patient Name: _____ Birthday: _____

_____ (initials) I have read and understand the information provided and would like to begin the Medication Compliance program at Hoagland Pharmacy.

_____ (initials) I authorize the use of non-child proof packaging for all of my medications.

_____ _____
(Signature) (Date)

_____ _____
(Printed Name) (Relationship to patient)

These signatures are required prior to the start of service. Please return completed form to Hoagland Pharmacy. Contact our compliance department at 685-5014 with any questions or concerns. Thank you.

Please complete one of the following autopay forms for any copays or monthly fees that may occur.

Hoagland Pharmacy
2330 Yew St
Bellingham, WA 98229
(360) 685-5002

Automatic Payment Form

Please check the type of card that you wish to authorize for transactions:

VISA _____ MasterCard _____ Discover _____ American Express _____

Credit Card #: _____-_____-_____-_____

Expiration Date on Card: _____ / _____

CVV code (3 digits on back): _____

Billing Address of Credit Card Holder:

_____

_____

Phone Number of Card Holder: (_____) _____ - _____

E-Mail of Card holder: _____

I authorize this card to be kept on file for future use. Yes____No ____

I authorize MERL Inc., dba Hoagland Pharmacy to charge my credit for purchases of products and / or services by the 7th of the month following the month the charges are incurred and to verify the billing address of my Credit Card with the issuing bank upon my signature. I understand that I am responsible for advising Hoagland Pharmacy of any changes in my credit card information. If Hoagland Pharmacy is unable to process my payment, I will be responsible for an alternate payment arrangement and any late fee which results. **I understand that a fee of 3% will be added for all Visa, Mastercard, and Discover transactions. I understand that a fee of 3.5% will be added for all American Express transactions.**

By signing this authorization, I acknowledge that I have read and agree to all of the above. All information given is complete and accurate.

Signature of Card Holder: _____

Printed Name of Card Holder: _____

Date of Signature: _____

Patient Name: _____

Hoagland Pharmacy
2330 Yew St
Bellingham, WA 98229
(360) 685-5002
Automatic Payment Form

Bank Name: _____

Routing Number: _____

Account Number: _____

Billing Address of Account Holder:
_____

_____

Phone Number of Account Holder: (_____) _____ - _____

E-Mail of Account Holder: _____

I authorize this card to be kept on file for future use. Yes____ No ____

I authorize MERL Inc., dba Hoagland Pharmacy to charge my account for purchases of products and / or services by the 7th of the month following the month the charges are incurred. I understand that I am responsible for advising Hoagland Pharmacy of any changes in my bank account information. If Hoagland Pharmacy is unable to process my payment, I will be responsible for an alternate payment arrangement and any late fee which results.

By signing this authorization, I acknowledge that I have read and agree to all of the above. All information given is complete and accurate.

Signature of Card Holder: _____

Printed Name of Card Holder: _____

Date of Signature: _____

Patient Name: _____

Hoagland Retail Pharmacy
2330 Yew Street
Bellingham, WA 98229
(360)734-5413

Hoagland LTC Pharmacy
1414 Meador Avenue, Suite H-102
Bellingham, WA 98229
(360)734-7544

Hours of Operation:
Mon- Fri 9:00 a.m. to 6:00 p.m.
Saturday 9:00 a.m. to 5:00 p.m.
Sunday - CLOSED

PATIENT INFORMATION

We maintain complete records of patient prescriptions. We'll ask you for information on this form now and it will be stored here permanently. You will be asked to give this information only once per individual.

Patient Name *(Last, First, M.I.)* _____ D.O.B. _____

Address: _____ Gender: ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ Phone: _____

If Minor, Parent's Name: _____

List Allergies: _____ ☐ None / No Known

Medical Conditions: _____

FILLING OPTIONS *(Please Choose)*

☐ Please sign me up for **Monthly Automatic Refills** on my routine medications.

☐ Please Fill My Prescriptions in **Safety Caps / Child Resistant Containers.**

☐ I would like **Non-Safety Caps.**

PAYMENT OPTIONS *(Please Choose)*

☐ Cash ☐ Insurance ☐ L & I ☐ Other _____

Patient Signature: *X* _____ **Date:** _____

Please fill out this page and return to pharmacy as soon as possible to begin services. Thank you.

Patient Name: _____ Birthday: _____

Insurance Info or SSN:

Current Pharmacy:
Current Physician(s):

Current Medlist: