InHome Pharmacy Care

"Calming the Medication Chaos"
661-258-3222

New Patient Form

Name:____ Date of Birth:________________
Address:____ Male/Female
Home Phone of Patient:________________________ Cell Phone:____________________
Known Drug Allergies:____
Prescription Insurance Info - Name of Insurance:_________________________________
Rx Bin #:_______ Rx PCN #:______ RX ID #:_____________ Rx Group # _________
Name of Pharmacy:______________________________ Phone:_____________________

Responsible Party Name:____
Address:____
Home Phone:____________________________ Cell:_____________________________
email:_____________________________ Relationship to Patient:___________________
Credit Card #:___________________________ Expiration:___________ CVV:________
Billing Zip Code:_______________ Preferred contact method:______________________

By signing below, I agree to accept responsibility for and guarantee payment of all charges for any service, medications and/or supplies rendered or delivered by *InHome Pharmacy Care*, hereinafter referred to as "the company". I also agree to pay in full and in a timely manner any outstanding balance so invoiced. Any outstanding balances due after 30 days will be charged a nominal finance charge of 1.25% interest (i.e. 15% Annual Percentage Rate). I further agree to pay all court costs, attorney's fees and collection costs so incurred to secure past due payments. I will notify the company in writing 30 days in advance of my intent to cancel this agreement.

My signature below also authorizes any entity, be they doctor or doctor's employee, pharmacist or any pharmacy personnel, insurance representative or other HIPPA-compliant entity to release and share necessary medical and/or non-medical information with any employee of the company in order for the company or its employees to provide services to the patient. All information shared with the company will be strictly guarded and only used to assist the patient with their medication management.

Signature of Responsible Party:_________________________________
Printed name:____
Date Signed:____

I agree to have medications delivered in NON-child safe packaging or containers. I specifically agree and acknowledge that it is my responsibility to keep these medications away from children and fully release InHome Pharmacy Care and its employees from any civil or criminal liability for not using child-safe or locking, safety closures on the medications delivered to the patient.

Signature of Responsible Party:_________________________________
Printed name:____

Date Signed:____

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New Patient Form

Name of Pharmacy:______________________________ Phone:_____________________

Please list all of the medications that you want to have delivered to the patient on a regular basis. Provide as much information as you have, but we will take care of tracking them down for you as well. List all prescription and non-prescription (over the counter) medications that are regularly taken.

Name of Medication Prescription Number Directions

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____
19. ____
20. ____

Please list any medications that are only taken on an as needed basis.

Name of Medication Prescription Number Directions

1. ____
2. ____
3. ____
4. ____

5. ____
6.____