Outpatient Intake Form

Patient Information

Patient Last Name (Please Print)	First Name	Middle Initial

Date of Birth:	Gender: ◯ M ◯ F	Physical Address:	Mailing Address (if different):

Phone Number:	Requested Start Date:	Social Security #:

Rx Bin:	Rx PCN:	Rx Group:	ID:

Previous Pharmacies & Phone Numbers:	Allergies:

Doctors & Phone Numbers:	Power of Attorney: □ Yes □No If yes, Name of POA: _____ (supporting documentation must be provided)

Filling Frequency: □28 days □ 14 days	Requested Packaging: □Bottles □Dispill Packaging (Multi-Med)	____ Initial to authorize cycle fill & automatic prescription refills

Caregiver Name & Phone Number (if applicable):	Emergency Contact & Phone Number:

How would you like to receive your prescriptions? ☐ **Delivery** ☐ **Pick-up** ☐ **Mail**

If mail or delivery, please indicate address & any special instructions: _____

_____

Authorized Individuals

The following individuals are authorized to reorder, pickup and receive medications for me. Please be aware Big Sky Managed Care will require ID to ensure medications are given to the appropriate person. I will notify Big Sky Managed Care if/when this information needs to be updated.

Authorized Individuals: _____

Please indicate delivery address, if different than patient's: _____

Patient Responsibility

Medication profiles are accurately maintained to the best of our capabilities; however, we cannot reasonably accommodate changes that are not communicated to us. Upon receiving medications, it is the patient/caregiver's responsibility to review the supplied materials for discrepancies such as discontinued meds, dose changes and missing medications. Any and all inconsistencies must be reported to the pharmacy in a timely fashion and we will do our part to ensure that orders are clarified and medication profiles are updated.

_____ ***Initials***

BIG SKY MANAGED CARE Rx

Montana Owned and Operated.

900 13th Ave S.
Great Falls, MT 59405

P: (406) 315-1989 F: (406) 315-1988
bigskymanagedcare.com

Child Safety Waiver

I request all medications, now and in the future, be dispensed in a non-child resistant container. I agree to waive the child-resistant safety cap requirement for all new prescriptions and refills. Big Sky Managed Care packs are not child safe and should be kept out of the reach of children at all times.

_____ ***Initials***

Repackaging Waiver

Repackaging Waiver of Liability: I understand I am requesting Big Sky Managed care to repackage my medications from their original containers into a multi-dose packaging system. Big Sky Managed Care reserves the right to repack medications when the manufacturer's guidelines recommend otherwise.

_____***Initials***

Privacy Notice

I certify that I have received a copy of the privacy notice (HIPPA) and have reviewed the document. I acknowledge Big Sky Managed Care, LLC is committed to protecting my health information.

_____ ***Initials***

Patient or Legal Representative's Signature

By signing below, I acknowledge I have read and understand all of the above initialed statements.

_____ _____

Signature **Today's Date**

Credit Card Authorization & Financial Responsibility

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type: MasterCard__ Visa__ Discover__ AMEX__ Other_____	
Cardholder Name: (as shown on card)	**Card Number:**
Expiration Date: (mm/yy)	**Billing Zip Code:**
CVV:	**☐ Auto Pay**
I _____, authorize Big Sky Managed Care to charge my credit card at the time of service for medications packaged for the above-named patient. I understand my information will be saved to file for future transactions on my account and I am financially responsible to Big Sky Managed Care, LLC for all charges incurred by the above-named patient, including copays, collection fees, etc. All non-covered medications and supplies will be billed to the patient or responsibly party, unless prohibited by state regulations. All statement balances shall be paid in full unless other arrangements are made. Any medications not picked up after 7 days will be mailed to the address on file. Upon discontinuation of service, your card will be charged for any outstanding balance.	
Signature:	**Date:**

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