DisPill Community Enrollment Form

Name (Last, First, MI):			Date of Birth:
Address:			Gender: □ Male □ Female
City:	State:	Zip Code:	Phone:
Known Allergies:			
Primary care physician:			

Delivery Preference (please check appropriate box):

□ **Pick-up** medications in store within 7 days of being filled

□ **Deliver** medications to my residence on the next available delivery day (restrictions may apply).

□ **Mail** my medications to my residence on the day they are filled (charges may apply).

Correspondence for the patient should be sent to (please check appropriate box):

□ **Patient** at the address listed above

□ **Other** please list name, relationship to patient, mailing address, phone number, and email below. Please note they will need to also sign the last page of this document**:**

Access To Records *(optional – complete for those individuals you will allow us to discuss your health with)***:**

I grant Hartzell's Pharmacy permission to share and discuss information concerning my treatment and health, including any Protected Health Information (PHI), with the following individuals (please list name and relationship to patient):

Payment Options:

□ **Credit Card** (MasterCard, Visa, American Express, and Discover accepted) processed at the time of service. Please call a valid credit card into the pharmacy for secure storage and processing.

□ **House Account** please complete a House Account Application and submit for a credit evaluation.

□ **Payment on Delivery** - check required

Advantages of the program include:

- Increased convenience – a single monthly trip to the pharmacy or single monthly delivery
- Peace of mind from being able to get medications on time and in one order
- Allows the pharmacy to partner with you in improving compliance to your maintenance medication regimens, understand your medications and disease states.
- An easy to use packaging system that makes it easy to manage and take medication.

Initials: _____

By enrolling in the Hartzell's Dispill program, I acknowledge and agree:

- That all oral solid medications (tablets and capsules) will be packaged utilizing Dispill-USA system. Liquids, topical creams and ointments, medications in unit-of-use packaging, eye drops, ear drops, dental preparations, and potentially other dosage forms will be sent separate from the Dispill-USA system.
- That Hartzell's Pharmacy will cycle fill my maintenance medications in a **28 day supply**. Cycle fill automates the delivery of the majority of an individual's maintenance medications, greatly reducing the number of reorders that need to occur.
- That I will have all of my prescription medications filled through Hartzell's Dispill Program. In a situation where that is not feasible (insurance coverage, etc), I will provide Hartzell's a written list of other medications I am currently taking. The list should contain medication name, strength, and how often you take it. I understand that I, or a caregiver, is responsible to make sure an updated listed is provided to Hartzell's in a timely manner.
- That Hartzell's Pharmacy will cycle up new medications in order to align them with the cycle. I understand this may require filling less than the amount prescribed on the prescription order.
- That As Needed (prn) and Non-Cycled Medication will be dispensed by Hartzell's Pharmacy in quantities compatible with the Dispill-USA format (day supplies divisible by 7 or quantities divisible by 28).
- That I will be billed monthly for all charges and have been provided information on payment terms with Hartzell's Pharmacy (page 2 and 3 of this document).
- To keep an open dialogue with my pharmacist regarding doctor's appointments, hospital/urgent care visits, and changes in my health status.
- That Hartzell's Pharmacy will charge **$10 per month for Adherence monitoring** by the pharmacy department.

Agreement for Services

By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the following terms:

1. **Authorizations:** Hartzell's Pharmacy, Inc. and its subsidiaries ("Hartzell's Pharmacy") are authorized to provide the Patient all products and services prescribed or ordered by the Patient's Physician(s). The Patient requests the products provided by Hartzell's Pharmacy be dispensed in containers that are not child resistant. The Patient requests that Hartzell's Pharmacy dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to pharmacy policy as allowed by professional standards and federal and/or state regulations.
2. **Legal Representative:** Legal Representatives will provide Hartzell's Pharmacy with documentation establishing their legal authority.

 Initials: _____

3. **Notice of Privacy Practices:** The Patient or their Legal Representative acknowledge that they have been informed that a copy of Hartzell's Pharmacy's Notice of Privacy Practices is available at www.hartzells.com. The Patient or their Legal Representative may at any time contact Hartzell's Pharmacy directly in order to request a copy of Hartzell's Pharmacy's Notice of Privacy Practices for their records.
4. **Assignment of Benefits:** The Patient or their Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Hartzell's Pharmacy for products and services provided to the Patient.
5. **Change of Custody:** The Patient or Legal Responsible and Financially Responsible Party acknowledge that once custody of products provided by Hartzell's Pharmacy has been transferred over to the Patient, either directly or through an intermediary such as a caretaker and/or family member, Hartzell's Pharmacy can no longer provide any credits or refunds due to federal and state regulations. Change of custody occurs at the point when products provided by Hartzell's Pharmacy are received by, or on behalf of, the Patient, are no longer in control of an employee of Hartzell's Pharmacy, and a signed document of receipt has been completed.
6. **Reliance and Consideration:** Hartzell's Pharmacy is relying upon the Financially Responsible Party's agreement herein in determining to provide products and services to the Patient, and Hartzell's Pharmacy's provision of products and services to the Patient constitutes good and adequate consideration for the Financially Responsible Party's agreements contained in this agreement.
7. **Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations:** The Patient or legal Representative hereby authorizes Hartzell's Pharmacy, its employee, agents and sub-contractors to disclose to the Medicare or Medicaid program or to any other third party payer any medical or other information needed for payment for all products and services provided by Hartzell's Pharmacy to the Patient until payment has been made in full. The Patient or Legal Representative further authorizes Hartzell's Pharmacy, its employees, agents and sub-contractors to use and disclose the Patient's medical and other information for the provision of products and services, for the business operations of Hartzell's Pharmacy, and for the review of Hartzell's Pharmacy's services, including review by accrediting bodies or government agencies.
8. **Modification:** No modification or amendment of this agreement shall be effective unless agreed to in writing by Hartzell's Pharmacy.

Patient and/or Legal Representative Signature of Agreement:

Patient

_____	_____	_____
Signature	Date	Printed Name

Legal Representative

_____	_____	_____
Signature	Date	Printed Name

Initials: _____