

Agreement to Participate in Hartzell's Pharmacy MyMedSync Program

Name (Last, First, MI):			Date of Birth:
Address:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
City:	State:	Zip Code:	Phone:
Medical Conditions:			
Known Allergies:			
Physicians <i>(please indicate type of practice and contact information)</i> :			
Preferred Contact - Name:			
Relationship to patient <small>(Please circle type of contact)</small> : Self Child Sibling Parent Other:			
Preferred contact number: _____ <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Mobile			
Alternate Contact - Name:			
Relationship to patient <small>(Please circle type of contact)</small> : Self Child Sibling Parent Other:			
Alternate contact number: _____ <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Mobile			
Delivery Preference <i>(please check appropriate box)</i> : <input type="checkbox"/> Pick-up <input type="checkbox"/> Deliver <input type="checkbox"/> Mail <i>(charges may apply)</i>			

Thank you for your interest in the MyMedSync program, a synchronized prescription refill service. The program works by lining up all your monthly medications to one particular day of the month, known as an appointment date. A pharmacist will call you 5-7 days prior to your date to discuss your medications and any possible changes or concerns. The pharmacy staff will deal with any issues, such as, refill requests, insurance issues, and medication changes on your behalf and have your prescriptions ready on your appointment date. At first it may take several months to get all your monthly medications lined up to the appointment date, but the staff will work hard with you to make it an easy transition. Advantages of participating in 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
- More personal contact with your pharmacist to ask questions and discuss your medications and disease states
- Increased understanding of your medication, its purpose, potential side effects and cost
- Allows the pharmacy to partner with you in improving compliance to your maintenance medication regimens, understand your medications and disease states.

I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the service. I hereby agree:

- To accept a phone call each month from the pharmacy to discuss my prescription refills.
- To pick up medications once they have been refilled within 7 days of your appointment date, according to the duration of therapy on the prescription OR be available on the date my medications will be delivered.
- If necessary, to pay an extra co-pay one time for each medication in order to make all refills due on the same day
- To keep an open dialogue with my pharmacist regarding doctor's appointments, hospital/urgent care visits, and changes in my health status.

I have read this document, understand it, and have had all questions answered satisfactorily.

Patient Signature

Date

Hartzell's to complete:

New Patient to Hartzell's: Yes No Employee doing enrollment: _____

Projected MMS Date: ____/____/____