Time My Meds® Program - Patient Agreement Form

Agreement to Participate in the Time My Meds Medication Synchronization Program

Thank you for your participation in the Time My Meds Medication Synchronization Program. You are on your way to achieving your most positive health outcome. Included below is a list of the many benefits.

- **UNDERSTAND** the importance of taking your medication(s) correctly and the impact it has on your health.
- **DECREASE** your trips to the pharmacy each month.
- **DISCUSS** medication costs, questions, and any possible side effects with your pharmacist.
- **RECEIVE** reminders to review your medication(s) and to pick up your medication(s) when ready.

I have reviewed and understand the above benefits of Time My Meds. By agreeing to participate in the program, I also agree to the following:

- I will provide and discuss my current medication regimen with the pharmacy
- I will work with the pharmacy staff on a regular pickup schedule
- I will pick up my medications each month

I understand the following communication plan:

- I will receive up to three (3) notifications per medication cycle
- I will provide my preferred method of communication
- I will notify the pharmacy if there have been any changes to my medication

☐ **I prefer communication by phone** ☐ **I prefer communication by text**

____
Phone/Mobile Number

I have read this entire document and understand the information that has been presented to me.

☐ **I authorize you to inform my physician(s) that I am enrolled in this program.**

Patient Name *(please print)*	DOB
Patient Signature	Date
Pharmacist Signature	Date

Omnicell, Inc. © Time My Meds®