PATIENT ENROLLMENT FORM

PATIENT INFORMATION

Name _____ Date of Birth _____ ☐ Male ☐ Female

Street Address, City State, Zip _____

Home Phone _____ Cell Phone _____ Who is the Primary Contact? ☐ Patient ☐ Caregiver

Caregiver Name _____ Caregiver Phone _____

Drug Allergies _____

PRESCRIBER INFORMATION

Name _____ DEA # _____ NPI # _____

Street Address, City State, Zip _____

Phone _____ Fax _____

CURRENT PHARMACY INFORMATION

Name _____ Phone _____ Fax _____

NON-PACKAGABLE MEDICATIONS

Liquids / Insulin / Inhalers

_____

_____

_____

_____

HIPAA Compliance

Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

PATIENT ENROLLMENT FORM

MEDICATIONS

Medication / Strength (Rx or OTC) ____ Quantity ____ Refills ____
☐ Morning ☐ Afternoon ☐ Evening ☐ Bedtime
Directions ____ Notes ____

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Directions ____ Notes ____

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KIRK'S PHARMACY INC.

PATIENT ENROLLMENT FORM

Kirk's Pharmacy Strip-packaging Program: Patient Agreement

We are pleased to welcome you to our coordinated refill program, using our strip-packaging technology.

Advantages of participating in the program include:

- Increased convenience – a single trip to the pharmacy each month, or direct to you mail service.
- Peace of mind from being able to get your prescriptions on time and in one order.
- Having all of your medications organized all together by when you need to take them.
- More personalized communication with the pharmacy to ask questions and discuss medications
- Your prescription records will be easily updated to reflect changes to therapy made by doctors and upon hospital discharge

_____ I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the Strip-packing Synchronization Program.

I hereby agree (initial each box appropriately):

- □ Pay the Monthly Packaging Fee of $5/box or an Annual Packaging Fee of $50 per year
- □ To accept a phone call each month from the pharmacy to discuss my prescription refills.
- □ To promptly call the pharmacy back if left a message regarding my prescription refills.
  - □ I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ANSWER THE PHARMACY CALL OR CALL THE PHARMACY BACK EACH MONTH TO DISCUSS MY MEDICATIONS SO THEY CAN BE PACKAGED APPROPRIATELY.
  - □ IF I DO NOT RETURN THE MESSAGES LEFT BY THE PHARMACY I WANT (CIRCLE ONE and CHECK APPROPRIATE BOX PER YOUR DECISION)
    - MY MEDICATIONS TO BE PACKAGED SAME AS LAST TIME
      - □ I will be responsible for any copays and medication changes that occurred that I did not notify the pharmacy of.
    - LEFT ON HOLD UNTIL I GET IN TOUCH WITH THE PHARMACY
      - □ I will be responsible for picking up my medications at the Puyallup location if needed next day (available after 2pm).
      - □ Deliveries will be made to Sunrise and Eatonville locations 2 days after contact.
- □ To pick up medications on my assigned pick-up date, or have my medications mailed, or be available for delivery, if applicable.
- □ If necessary, to pay an extra co-pay *one time* for medications requiring a short fill to be synced with my other medications.
- □ To keep an open dialogue with my pharmacist regarding doctor appointment, hospital/urgent care visits, and changes in my health status or medication regimen.

I request non-safety caps for all of my prescriptions from this point forward, and understand that due to the nature of the packaging, my medications will not be in child resistant packaging.
I have read this document, understand it, and have had all questions answered.

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