Agreement to Participate in the

Synchronized Prescription Refill Service

Thank you for your interest in the Synchronized Prescription Refill Service. Advantages of participating in the program include:

- Increased convenience—a single monthly trip to the pharmacy
- 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 medications
- Increased understanding of your medication, its purpose, potential side effects and costs
- Your prescription records can be more easily updated to reflect changes therapy made by doctors or upon hospital discharge

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 on my assigned refill date.
- If necessary, to pay an extra copay *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 Name (*Please print*)

_____ _____

Patient Signature Date

_____ _____

Pharmacist Signature Date

_____

Pharmacy Name