

## Patient Agreement

We are pleased to welcome you to **Simplify My Meds™**, our coordinated refill program.

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 the pharmacist to ask questions and discuss medications.
- Increased understanding of your medication, its purpose, potential side effects and costs.
- Your prescription records will be easily updated to reflect changes to 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 Simplify My Meds program.**

***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 (or be available for delivery, if applicable).
- 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 appointments, hospital/urgent care visits, and changes in my health status.

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

\_\_\_\_\_  
Patient Name (*please print*)

\_\_\_\_\_  
Phone Number (*cell*)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Pharmacist Signature

\_\_\_\_\_  
Date