Fobi Comprehensive Pharmacy, Inc.

7922 ROSECRANS AVE STE. P2; PARAMOUNT CA 90723
PH: 562-630-5700 FAX: 562-630-5705

ATTACHEMENT A

CONSENT TO PARTICPATE IN MEDICATION CYCLE REFILL

Patient: _____ **DOB:** _____

I, the undersigned, hereby select Fobi Comprehensive Pharmacy as my pharmacy of choice consent to and authorize my medications to be synchronized and refilled each month as a service provided by the pharmacy. Fobi Comprehensive pharmacy has explained to me their cycle refill procedure (Medication Synchronization) as defined below.

Medication synchronization. At Fobi Comprehensive pharmacy we coordinate our patient's medications to be filled at the same time each month. It moderates barriers to taking medications daily, on time as prescribed (e.g., forgetfulness, complex medication schedules, difficulty taking medications, patient's understanding of either the medication or disease state), helps eliminate therapy interruptions, identifies non-adherence in the home or changes in therapy, reduces first-fill abandonment and improves patient-pharmacist interaction.

I understand that by signing this authorization:

- I have the right at any time be able to withdraw a prescription medication from cycle refill or to disenroll entirely from the program at any time.
- I have the right to receive a copy of this authorization

Signed by Patient:	Date
Or Signed by Patient's Representative: On Behalf of _____ **Name of Patient**	Date