227 Main Street, Fort Fairfield, ME 04742
Phone: 207-472-1302 ♥ 1-888-422-7319
Fax: 207-472-1580 ♥ 1-877-422-7319
WWW.I-CAREPHARMACY.COM

Dispill Multi-dose Packaging Program

Agreement and Enrollment Form

Thank you for your interest in I Care Pharmacy's Dispill Synchronized Prescription Program. Advantages of participation in the program include:

- Increased convenience- have your maintenance medications shipped together once per month in 7 day blister pack sheets with pills presorted in individual time of day cells;
- Medication adherence- Dispill packaging clearly show you what time each day to take your medications and provide verification you are on the proper schedule;
- Improved health- through more organized medication scheduling and adherence;
- Portability- no need to take all medication vials with you when you travel, instead, take just the number of days needed in the convenient time-of-day packs;
- Refill reminders- our Patient Care Coordinators will call you monthly to check for any medication changes and ask for your approval to mail your refills to you;
- Access to Pharmacists- regular access to pharmacists for questions and counseling.

I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the service.

I hereby agree to:

- Accept monthly phone calls from I Care Pharmacy to discuss my prescription refills.
- Accept 28 day medication supplies via the US Postal Service for my prescriptions.
- Receive my medications in packaging that is NOT child resistant.
- If necessary, pay additional copays in order to make all refills due on the same day- called "synchronization".
- Keep an open dialogue with I Care Pharmacy regarding doctor appointments, hospital/urgent care visits and all changes in my prescriptions.
- Designate an Emergency Contact and/or Care Provider below that can be called to discuss my prescription information if I Care Pharmacy staff is unable to reach me.

By my signature below, I agree to the terms and conditions of enrollment in the Dispill Program until I notify I Care Pharmacy of my disenrollment.

_____ _____
Patient Name (printed) Emergency Contact Name & Phone Number

_____ _____
Patient Signature/Legal Guardian (if minor) Home Care Provider & Phone Number

_____ _____
Patient Phone Number Date

"Maine's Mail Order Pharmacy"

Patient Set-up Information required for Dispill Program

Patient's Name: _____ DOB: _____ Gender: M_____ F_____

Address: _____

_____

_____

Telephone#: (____) _____ Alt Telephone #: (____) _____

SS #: _____

Insurance Name: _____

ID #: _____ BIN #:_____ PCN #:_____

Group ID: _____

List of Medication Allergies & Reactions if known: List of Medication Allergies & Reactions if known:

_____

_____

_____

Current Pharmacy Name:_____Phone#:_____

Current Prescriber(s):_____Phone#: (____)_____

Current Prescriber(s):_____Phone#: (____)_____

Current Prescriber(s):_____Phone#: (____)_____

Must complete the following form with list of medications & time of day administered: See attached

"Maine's Mail Order Pharmacy"

Please list all medications you are requesting to have in your planner, and indicate the amount taken at the appropriate time slot.

MEDICATION	DIRECTIONS	AM	NOON	EVENING	BEDTIME
EX. ASPIRIN 81 MG	*TAKE 1 TABLET BY MOUTH DAILY.*	*1*			

"Maine's Mail Order Pharmacy"

Automatic Credit/Debit Card Charge Authorization Form

227 Main Street
Fort Fairfield, ME 04742
Phone: 1-888-422-7319 Fax: 1-877-422-7319

By signing this form, I authorize I Care Pharmacy to automatically charge my credit or debit card for the cost of my prescription purchases as specified below. I understand that I will not receive a phone call in advance. I may cancel this automatic charge authorization at any time by providing I Care Pharmacy with a 15 day written notice.

I, _____, hereby authorize I Care Pharmacy to charge my credit/debit card as specified below for co-pays due.

_____
Mailing Address (Street or P.O. Box) City State Zip Code

_____ _____ _____
Card number (Visa/MasterCard/Discover) Exp. Date CVC/CVV*

_____ _____
Client E-mail Address Telephone number

_____
Cardholder's Billing Address as shown on credit card statement (if different than above)

_____ _____
Name as it appears on Card (please print) Card holder's signature

For your convenience, please indicate option below for credit/debit card charge authorization.

☐ Monthly: Automatically charge the monthly statement balance on the 3rd of each month.

☐ Automatically charge for copay amount at the time of each prescription fill.
(If copay amount is under $3.00, your card may not be charged until the beginning of the following month.)

- ***Your credit/debit card information will be kept secure and will only be used for the purpose of payment for your prescription purchases.***
- ***If your automatic charge fails due to insufficient available funds, I Care Pharmacy reserves the right to terminate this agreement and require pre-payment of purchases.***

*3 Digit Security Code (CVC or CVV) is located on the back of your credit card to the right of credit card number.

"Maine's Mail Order Pharmacy"

Authorization for Release of Protected Health Information

227 Main Street, Fort Fairfield, ME 04742
Phone: 888-422-7319 Fax: 877-422-7319
www.i-carepharmacy.com

Completing this form allows I Care Pharmacy to give your health information or records to a third party such as a caregiver, family member or law office.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I, or my personal representative, authorize I Care Pharmacy to release my health information, prescription history, and/or any other pharmacy services I have received from I Care Pharmacy as follows:

1. My health information may be released to the following person(s) or group(s):

   Name(s): _____ Relationship to Patient: _____

   Address: _____ Phone Number: _____

2. Specific information to be released (select all that apply):

   - ☐ Entire Prescription History
   - ☐ Financial/Copay Information
   - ☐ Prescription History from (date) _____ to (date) _____
   - ☐ Other (please specify): _____

3. I understand that my health information may include material used to treat mental health conditions, alcohol or substance abuse, HIV/AIDS, or sexually transmitted diseases.

   - ☐ I authorize release of this information.
   - ☐ I DO NOT authorize release of this information.
   - ☐ I authorize ONLY the following information: _____

4. I understand that information released to a third party may no longer be protected by federal or state laws and may be released by the person or group that receives the information.
5. I understand that a photocopy of this authorization shall be considered as valid as the original.
6. I understand that authorizing the release of my health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to enroll, receive treatment or payment, or to be eligible for benefits.
7. This authorization may be canceled by my written request at any time to the following address. The cancellation will not apply to any information shared before that date.

Privacy Official
I Care Pharmacy
227 Main Street
Fort Fairfield, ME 04742

Patient Signature: _____ Today's Date: _____

"Maine's Mail Order Pharmacy"

I Care PHARMACY

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Non-Signature Delivery / Non-Safety Cap Authorizations

Your Health Insurance Prescription Plan may require a signature confirmation when your medication is delivered. If you prefer not to sign for your package, please complete and return this form.

By signing below, you agree to the following:

1. I have requested the medication be filled by I Care Pharmacy.
2. I agree that standard delivery confirmation from the U.S. Postal Service will serve as an acknowledgment of receipt of my medication.
3. I will pay any co-pays incurred as outlined in my welcome letter.
4. I assume all responsibility to report any damaged, lost, and/or stolen packages to the U.S. Postal Service.
5. This agreement will remain in effect until either party gives verbal or written notice to revert to U.S. Postal Service signature confirmation delivery.
6. Schedule 2 controlled substances will ALWAYS require a signature for delivery.

Your prescriptions will remain signature confirmation as required until this form is returned to us. Please contact us with any questions.

Printed Name: ___________________________________ Date of Birth: __________________

Signature: ______________________________________ Today's Date: __________________

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NON-SAFETY CAP AUTHORIZATION

Federal regulations require that most medications be packaged with child-resistant "safety" caps. Your signature below indicates your desire to have medications dispensed with **easy open caps**.

Signature: ______________________________________ Today's Date: __________________

"Maine's Mail Order Pharmacy"