I Care PHARMACY
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	Home Care Provider & Phone Number
Patient Phone Number	Date

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:**

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____

____

Current Pharmacy Name:_____________________________Phone#:_____________________________

Current Prescriber(s):______________________________Phone#: (____)_______________________

Current Prescriber(s):______________________________Phone#: (____)_______________________

Current Prescriber(s):______________________________Phone#: (____)_______________________

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

Automatic Credit/Debit Card Charge Authorization Form

"Maine's Mail Order Pharmacy"

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.

☐ Bi-Monthly: Automatically charge the current balance on the 3rd & 15th of each 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"

227 Main Street
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I-carepharmacy.com

To Our Valued Customer:

Your **Health Insurance Prescription Plan** requires a signature confirmation when your medication is delivered or picked up. We realize it may be an inconvenience for our customers to sign for their prescriptions at the time of delivery. If you would prefer to not be required to sign for your packages, please complete this form and mail it back to us.

By signing below, you agree to the following:

1. **You have requested the medication to be filled.**
2. **You agree that delivery confirmation from the United States Postal Service will serve as an acknowledgment of receipt of your medication.**
3. **You will pay any co-pays that may be due to us in a timely fashion.**
4. **You will assume all responsibility for any damaged, lost, and/or stolen medications.**
5. **This contract will remain in effect until revoked by either party.**

Print Name: ___________________________________

Date of Birth: __________________________________

Signature: _____________________________________ Date: ___________________

Your prescriptions will continue to be sent requiring you to sign for them until this letter is returned to us. Please feel free to contact us if you have any questions.

Sincerely,

I Care Pharmacy

PHARMACY USE ONLY

After updating the patients' record, initial and date the appropriate blank and forward to the Patient Care Coordinator.

Initials __________ Date ____________ ID Verified by ________________________

"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	EVENIN G	BEDTIME
EX. ASPIRIN 81 MG	*TAKE 1 TABLET BY MOUTH DAILY.*	*1*			

"Maine's Mail Order Pharmacy"