Free Monthly Synchronized Prescription Refills

Thank you for your interest in the ScriptSync 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

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

I hereby agree:

- To accept phone calls prior to my next refill date to discuss my prescription refills.
- To keep an open dialogue with my pharmacist regarding doctor's appointments, hospital/urgent care visits and changes in my health/medication status.
- If necessary, to pay an extra copay or accept "short fills" in order to make all refills due on the same day.

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

______________________________ ______________________ ____/_____/______
Patient Name (Please Print) Patient Contact Number Date of Birth

______________________________ ______________________
Caregiver Name (Please Print) Caregiver Contact Number

Is caretaker the primary contact? (please circle) **YES NO**

______________________________ ______________________________
Patient Signature Pharmacist Signature

Auto Delivery yes no ____
If yes, please provide delivery address

Auto Charge yes no
(see monthly credit card on file form)

HIPAA Compliance: *Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.*