***Kirk’s Pharmacy Strip-packaging Synchronization Program:***

***Patient Agreement***

We are pleased to welcome you to our coordinated refill program, using our strip-packaging technology.

**Advantages of participating in the program include:**

* Increased convenience – a single trip to the pharmacy each month, or direct to you mail service.
* Peace of mind from being able to get your prescriptions on time and in one order.
* Having all of your medications organized all together by when you need to take them.
* More personalized communication with the pharmacy to ask questions and discuss medications
* Your prescription records will be easily updated to reflect changes to therapy made by doctors and upon hospital discharge

**\_\_\_\_\_ I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the Strip-packing Synchronization Program.**

**I hereby agree** (initial each box appropriately):

* Pay the Monthly Packaging Fee of $5/box or an Annual Packaging Fee of $50 per year
* To accept a phone call each month from the pharmacy to discuss my prescription refills.
* To promptly call the pharmacy back if left a message regarding my prescription refills.
* I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ANSWER THE PHARMACY CALL OR CALL THE PHARMACY BACK EACH MONTH TO DISCUSS MY MEDICATIONS SO THEY CAN BE PACKAGED APPROPRIATELY.
* IF I DO NOT RETURN THE MESSAGES LEFT BY THE PHARMACY I WANT (CIRCLE ONE and CHECK APPROPRIATE BOX PER YOUR DECISION)
  + - MY MEDICATIONS TO BE PACKAGED SAME AS LAST TIME
      * I will be responsible for any copays and medication changes that occurred that I did not notify the pharmacy of.
    - LEFT ON HOLD UNTIL I GET IN TOUCH WITH THE PHARMACY
      * I will be responsible for picking up my medications at the Puyallup location if needed next day (available after 2pm).
      * Deliveries will be made to Sunrise and Eatonville locations 2 days after contact.
* To pick up medications on my assigned pick-up date, or have my medications mailed, or be available for delivery, if applicable.
* If necessary, to pay an extra co-pay *one time* for medications requiring a short fill to be synced with my other medications.
* To keep an open dialogue with my pharmacist regarding doctor appointment, hospital/urgent care visits, and changes in my health status or medication regimen.

**I request non-safety caps for all of my prescriptions from this point forward, and understand that due to the nature of the packaging, my medications will not be in child resistant packaging.**

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

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Patient Name (*please print*) Patient Date of Birth

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Patient, POA, Caregiver Signature Date

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Pharmacist Signature Date