Agreement to Participate in the Discount Drug Mart *SYNC your MEDS* Program

Thank you for your interest in our ***SYNC your MEDS*** program, a synchronized prescription refill 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.

* Increased understanding of your medication, its purpose, potential side effects, and costs.

* Your prescription records can be more easily updated to reflect changes to therapy made by doctors or upon hospital discharge.

I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the service at this Discount Drug Mart location and hereby agree:

* To accept a phone call each month from the pharmacy to discuss my prescription refills.

* To have prescriptions included in the ***SYNC your MEDS*** program processed and filled for a one month supply.

* To pick up medications on my assigned Appointment Date.

* To pay an extra co-pay ***one time*** for each medication ***if necessary*** in order to make all refills due on the same day.

* To keep an open dialogue with my pharmacist regarding doctor's appointments, hospital/urgent care visits, and changes in my health status.

*To not participate in our Auto Prefill or Refill Reminder program while using ***SYNC your MEDS***

* To allow our pharmacy staff discuss your medication profile as part of our ***SYNC your MEDS*** program with your caregiver(s). If yes, initial here _____. Print name(s) of caregiver(s) in space provided below.

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

_____
Patient Name (*Please print*)

_____
Caregiver(s) Name(s) (if applicable) (Please print)

_____ _____
Patient Signature Date

_____ _____
Pharmacist Signature Date

Patient may opt-out of the ***SYNC your MEDS* at any time by informing your DDM Pharmacist in person or by phone. The pharmacist will document the opt-out-request (name, date, and time) on this Patient Agreement Form.