MedSync Program Enrollment Form

Thank you for your interest in our MedSync 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 AllHealth Network Pharmacy and hereby agree:

- To accept a phone call each month from the pharmacy to discuss my prescription refills.
- To have prescriptions included in the MedSync program processed and filled for a one month supply, unless otherwise specified.
- 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 allow our pharmacy staff discuss your medication profile as part of our MedSync 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)                                               Date

__________________________________________  _______________________________________
Caregiver(s) Name(s) (if applicable) (Please print)                        Date

__________________________________________  _______________________________________
Patient Signature                                               Date

__________________________________________  _______________________________________
Pharmacist Signature                                             Date

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