ScriptAlign®
A Better Way to Better Health
PMC's Concierge Program

Customer Enrollment Forms

GETTING STARTED IS AS EASY AS 1, 2…3!

1) Complete Enclosed Information *(Make Copies of Additional Pages if Necessary)*

2) Sign *(On the Bottom of Page 4)*

3) Mail or Email Back to PMC PHARMACY *(Address & Phone are at the Bottom of Page 4)*

TODAY'S DATE: _____ CHECK ONE (SCRIPTALIGN® ☐ SCRIPTALIGN® VIP - VISUALLY IMPAIRED ☐)

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ EMAIL ADDRESS: _____

PATIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MEDICATION ALLERGIES: _____

_____

CAREGIVER'S INFORMATION: NAME: _____

PHONE # _____ EMAIL _____

_____

INSURANCE COMPANY: _____ INS. CO PHONE: _____

- ID #: _____ RX BIN #: _____ PCN: _____ GROUP #: _____

HOW DID YOU HEAR ABOUT PMC PHARMACY AND WHY DID YOU DECIDE TO SWITCH TO SCRIPTALIGN®?: _____

_____

_____

GENERAL NOTES (ANYTHING YOU THINK MIGHT BE IMPORTANT): _____

_____

_____

_____

Page 1…(Continue to Page 2 for Medication Detail)

PMC® Pharmacy
We Bring The Pharmacy To You!

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MEDICATIONS / OTC'S / SUPPLEMENTS

Please tell us about **ALL** Prescriptions, OTC's and Vitamins/Supplements you would like PMC Pharmacy to Provide in your ScriptAlign® Packaging

MEDICATION / OTC / SUPP NAME	STRENGTH	DIRECTIONS FOR USE	# REFILLS REMAIN	EST. DAYS SUPPLY REMAIN	MEDICATION TIMES TAKEN (EX: BREAKFAST / LUNCH / DINNER / BED-TIME)	PRESCRIBING PHYSICIAN NAME (Provide Detail on Page 3)	CURRENT PHARMACY NAME (Provide Detail on Page 3)

****** Please Print out a Second Sheet if necessary ******

Page 2…(Continue to Page 3 for Doctor & Pharmacy Detail)

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DOCTORS/PRESCRIBERS & PHARMACY INFORMATION

Please provide us with the names of your Doctors and Pharmacies and we will transfer your Prescriptions for you

PRESCRIBING PHYSICIAN / PRACTICES(S):

1) NAME: _____ TOWN/ST: _____ PHONE: _____
2) NAME: _____ TOWN/ST: _____ PHONE: _____
3) NAME: _____ TOWN/ST: _____ PHONE: _____
4) NAME: _____ TOWN/ST: _____ PHONE: _____
5) NAME: _____ TOWN/ST: _____ PHONE: _____

CURRENT PHARMACY / PHARMACIES:

1) NAME: _____ TOWN/ST: _____ PHONE: _____
2) NAME: _____ TOWN/ST: _____ PHONE: _____

NOTICES – PLEASE READ (SIGNATURE REQUIRED BELOW)

Notice of Privacy Practice - Federal Regulations require that PMC Pharmacy obtain proof that Customers have received the Notice of Privacy Practices **(Policy included).**

Notice of Non-Child Resistant Packaging - Regulations require that PMC dispense all Oral Medications in Child Resistant containers or systems. ScriptAlign® packaging is **NOT** Child Resistant. I am requesting a waiver of this regulation and that all current medications be dispensed in a "Non-Child Resistant" container or system, and understand that Child Resistant Packaging is available. I also understand that "Non-Child Resistant" packaging is not recommended for households with small children.

Notice of Patient Responsibility – I understand that it is my responsibility to inform PMC Pharmacy, as soon as possible, of any medication changes. This is the only way to ensure accuracy of PMC's ScriptAlign® packaging. It is PMC's policy to deliver the medications listed in our active medication list each month unless otherwise informed. I understand that if my ScriptAlign® packaging has already been assembled, and if a new medication was added to my medication therapy or if prescriptions from my physicians are received after assembly, my medication may be provided in a vial for the current month.

General Program Services and Member Responsibilities

Concierge Services Program Elements. Features subject to change.

a. Annual Review with a Pharmacist: 45 minute, appointment based, medication and wellness review service. The customer must schedule their annual review in advance.
b. Therapeutic Continuity Plan: Each month, PMC Pharmacy will provide a ScriptAlign® Medication Box and your medication regime. Unless notified by Member in advance of shipping, each month the Medical Box and medication regimen will be exactly as it was in the prior month's delivery.
c. Nurse Navigator Services: PMC Pharmacy will provide a team to ensure that medications are reconciled across all providers about whom PMC Pharmacy is aware. The team will answer questions and work with providers to ensure that prescriptions are issued timely.
d. Free Delivery: Members receive up to 3 free medication deliveries per month.
e. Online Store Member Discount: Members receive a 10% discount off of all purchase at PMC Pharmacy's Online Store.
f. Custom Adherence Packaging: Prescriptions will be shipped in packaging customized to Member's daily routine.

Member's Responsibilities:

a. Pay the Fee. Member is responsible for the monthly membership fee of **$135/Month less applicable discounts**.
b. Provide accurate credit card information to ensure payment of the Fee.
c. By signing below, agree to the Conditions and Limitations listed on our website at https://pmcrx.com/.
d. Sign below acknowledging receipt of Notice of Privacy Practices.
e. Provide truthful and accurate information to PMC Pharmacy.

(My Signature below indicates that I agree to the **Notice of Privacy Practice,** the **Notice of Non Child Resistant Packaging** Terms above, the **Notice of Patient Responsibility** and the **General Program Services and Member Responsibilities**.

Patient or Legal Guardian Signature	Date

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Email: info@pmcrx.com