Simplify My Meds Enrollment Form

Patient Info

Patient ID__Assigned by pharmacy__ Date_____

Name_____ DOB_____
Last Middle First

Address_____City_____ State_____ Zip _____

Home Phone_____ Cell Phone_____ Email_____

Primary Care Physician (PCP) _____ PCP Phone_____

Delivery Address_____ City/St/Zip_____

EmergencyContact(name/phone)_____

Allergies:

Insurance Info (if new to Central Drugs)

Insurance carrier/Plan_____ Plan Group #/ID#_____

Medical #/Issue Date _____ Insurance Phone_____

Medicare #_____ Medicaid # (if applicable)_____

Adtnl/Secondary Insurance_____ ID#_____ BIN#_____ PCN#_____

Payment Information

Credit Cards will be charged once a month for the full account balance. Receipt will be delivered to you.

☐ VISA ☐ Mastercard ☐ AMEX ☐ Discover

Name on card _____

Card Number _____ Exp. Date _____ CID # _____

Patient Signature _____ Exp. Date _____

La Habra
520 W. La Habra Blvd.
La Habra, CA 90631
562.691.6754

Fullerton
1955 Sunnycrest Drive #100
Fullerton, CA 92835
714.515.1530

CentralDrugsRx.com

Simplify My Meds Authorization Consent Form

Central Drugs Compounding Pharmacy offers a unique program to help patients better manage their prescriptions. Simplify My Meds synchronizes a patient's maintenance medications so that they may be filled at the same time every month. We notify the patient's doctor when insurance no longer covers a medication or when they need refills.

Central Drugs accomplishes this by filling the patient's prescriptions on a 28-day cycle. This prevents running out of medication on weekends in the event that the doctor's office is closed. We are committed to providing the best service in the industry, and that is why we will deliver the patient's medication at no charge. In addition, Simplify My Meds also sets the patient up on our My Dose Alert system to notify them via phone call, text, or even email when it is time for every dose of their medication.

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

I hereby agree:

- To accept a phone call each month from the pharmacy to discuss my prescription refills.
- To pick up medications on my assigned refill date (or be available for delivery, if applicable).
- If necessary, to pay an extra co-pay one time for each medication in order to make all refills due on the same day.
- To keep an open dialogue with my pharmacist regarding doctor appointments, hospiatal/urgent care visits, and changes in my health status.

Patient Signature _____ Date _____

Simplify My Meds Medication Re-Packaging Form

I, _____ understand and agree that Central Drugs Compounding Pharmacy will need my current medication which is listed below, to get me started on Simplify My Meds. If I have more pills than needed to fill my first personalized box, Central Drugs will put the extra pills in a container with the proper label and hold it for next month. Central Drugs will continue this until all the medication I gave them is depleted (runs out). If I do not have enough medication to fill my first personalized box, Central Drugs will use medication from their own stock. I understand pharmacies use different pharmaceutical suppliers, and for this reason a Central Drugs pharmacist will inform me that my medication may have a different name, color, or shape, but the formulas of the drug are the same.

Patient Name _____ Phone _____ Date _____

Medication - Name and Strength	Prescribing Doctor	Directions	Qty on Hand	Notes

Patient Signature _____ Date _____

Central Drugs Staff Signature _____ Date _____

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