**Sample Patient Participation Agreement for an ABM Program**

Thank you for your interest in the Synchronized Prescription Refill Service. Advantages of participating in the program include:

* Increased convenience—a single monthly trip to the pharmacy to pick up chronic medicines;
* Ability to get medications on time and in one order without calling the pharmacy for refills;
* More personal contact with your pharmacist to ask questions and discuss medicines;
* Increased understanding of your medication, its purpose, potential side effects and costs;
* Assistance from pharmacy staff to keep prescriptions in order as you visit various doctors, clinics, and hospitals.

**I understand the program advantages and the following conditions of participation to achieve the maximum benefits from the service.**

***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.
* 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’s appointments, hospital/urgent care visits, and changes in my health status.

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

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Patient Name (*Please print*)

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Patient Signature Date

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Pharmacist Signature Date