LINCOURT PHARMACY
Automatic Monthly Refill Reminder Program
ENROLLMENT FORM

I wish to enroll in the Lincourt Pharmacy Refill Reminder Program. I give Lincourt Pharmacy representatives permission to call the phone number(s) I list below to notify me when my medication is due for refilling and to authorize the refill. I understand that Lincourt Pharmacy will make its best effort to contact me by the phone numbers I list below before disposition of my maintenance medications. If I can not be reached, I understand my medications may not be ready upon patient request for delivery or pick-up.

I may cancel my participation in the Refill Reminder Program at any time by simply notifying Lincourt Pharmacy. The program may be cancelled by Lincourt Pharmacy at any time with notification. It is my responsibility to **notify Lincourt Pharmacy when there is a change in my maintenance medication therapy.**

For medication refill notifications the pharmacy may call the numbers listed below:

Primary:

1) ( ) -

Alternates:

2) ( ) -

E-Mail: @

/ /

Name Date of Application

Address

City, State, Zip

Signature

Medications I wish to have included in the program:

1) 4)

2) 5)

3) 6)

Use back to list others.