Medicine Man Southwest Pharmacy
805 E. Polston Ave.
Post Falls, ID 83854
(208) 777-7732

Automatic Refill Program

Customer Name: ______________________________

Mailing Address: ______________________________

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Phone number: ______________________________

What is your Current Prescription Insurance Plan? ______________________________

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(We will need a copy of your current card, if we have not yet billed this insurance for you)

For AutoRefill Mail we will need a current credit card number and expiration date to keep on file.
If you are requesting AutoRefill Pickup, we will not need a credit card on file.

Credit Card # ______________________________ Exp Date: ______________

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Signature for charges to credit card

List your prescriptions for Auto Filling:

Prescription drug / Prescription number

______________ / ______________

______________ / ______________

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TERMS OF SERVICE: We will fill and mail your prescriptions listed above, to the mailing address indicated, and charge your payment to the credit card indicated above. (For autofill pickup, payment will be collected when you pickup the prescription order.) There will be no charge for mailing. However, it is YOUR RESPONSIBILITY to give the pharmacy ten (10) days notice prior to the next filling date of your prescription(s), so that e we can discontinue or change the service in a timely manner when the following situation(s) arise: (a) you have discontinued a prescription. (b) your prescription has changed. (c) you have decided to no longer have the prescription(s) automatically refilled and sent to you, (d) your mailing address, phone number, credit card information or insurance information has changed. In addition you must notify the pharmacy as soon as possible if you do not receive your prescription(s) on time, so that we can take action to correct the situation.

CUSTOMER SIGNATURE: ______________________________ **DATE:** ______________

Please sign here to indicate your acceptance of the terms for this service. In addition by signing here you are authorizing the pharmacy to bill your insurance and acknowledging that you are requesting automatic refill service, therefore your signature will be for the receipt of your prescription for insurance purposes when your prescription(s) are mailed to you.