



Medicine Man West Pharmacy
802 E. Medical Court
Post Falls, ID 83854
(208) 773-3566

Automatic Refill Program

Customer Name: _____

Mailing Address: _____

Phone number: _____

What is your Current Prescription Insurance Plan? _____

(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: _____

Signature for charges to credit card

List your prescriptions for Auto Filling:

Prescription drug / Prescription number

Form with 7 rows for listing prescription drug and prescription number, separated by a slash.

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 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.