Automatic Refill Program

NO HASSLE, NO RE-ORDERING, NO WAITING

Patient Name:____

Mailing Address:____

City:____________________________ State:_______ Zip:__________________

Cell Phone #: __________________________ Daytime Phone #: _____________________________

Email:____

☐ YES, enroll me in the automatic refill program.

☐ NO, I do not want to participate in the automatic refill program.

Medication Name:____

RX NUMBER:____

____ __________________

Patient Signature Date

Please sign above to indicate your acceptance of the terms of this service. You are authorizing the pharmacy to refill your prescription automatically, at the appropriate time, and to bill your insurance. Your prescriptions will be mailed to you at the above mailing address at no additional charge. You are authorizing the pharmacy to call your physician for a renewal if no valid refills remain on your prescription. It is your responsibility to notify the pharmacy if any of the above contact information changes. You may cancel automatic refills at any time by contacting the pharmacy at (281)453-7250.

PLEASE SEND COMPLETED FORM TO THE PHARMACY

FAX: (281)453-7242

Email: info@expressspecialtypharmacy.net

AUTOMATIC REFILL PROGRAM, 20320 Northwest Freeway Ste 900, Houston, Texas 77090