



MEDICATION DISPENSING PROGRAM

This is to inform you that we have implemented an in-office Medication Dispensing Program, primarily for sick patients, to save a trip to the pharmacy.

This is an added value service option. The service is being provided as an added convenience to our patients, at prices comparable to those offered at your local pharmacy or you insurance co-pay.

We do not accept insurance for this service, or file forms for insurance.

You may submit your receipt for flexible spending accounts if you wish to do so.

If you would like to participate in this service OPTION please acknowledge your desire to participate with your signature below:

I, _____ am interested in participating in the Medication Dispensing Program. I understand the Medication Dispensing Program is an OPTION offered to me. I am neither obligated nor required to participate.

Patient Signature

Date