CLAREST HEALTH – PHARMACY AGREEMENT

Patient Name:_____ DOB: _____

I agree to the following regarding Clarest Health pharmacy services:

1. To have all of my current maintenance medications transferred to **Clarest Health** #7931, LLC pharmacy
2. To receive all of my medications in non-childproof packaging, and that I acknowledge that it is my responsibility to store medications in a safe, secure location. Going forward, I release the pharmacist/pharmacy (Clarest Health) from liability for not using the safety closure container.
3. To pay all charges not accepted from my insurance source, including any non-covered items, co-pays, and over-the-counter items.
4. I understand that if this account becomes past due, it may result in a disruption or termination of services and an attempt to collect fees. I understand that I will be held responsible for all costs and expenses incurred by the pharmacy in the collection of amounts owed.
5. I will promptly notify Clarest Health pharmacy of any address, phone number, or insurance changes.
6. I understand that medications and items received through shipment are non-returnable.
7. I was offered a copy of the Clarest Health Notice of Privacy Practices, and may request a Medical Information Release Form, if needed, to authorize other individuals to have access to my health information.
8. I understand that I have the right to consult with a pharmacist and ask questions about my medications. I may contact the pharmacy at 877-865-2902.
9. I authorize Clarest Health to ship medications to my designated address via USPS mail or commercial common carrier, and understand that certain prescriptions (such as controlled substances) may require a signature upon delivery.

_____ _____

Signature of Patient / Responsible Person Printed Name

_____

Date