



Make all of your prescription refills EASY at Kinney Drugs!

Enjoy the convenience of automatic prescription refills with *ReadyScripts* at Kinney Drugs and never worry about running out of your medication again.

Just follow these simple steps and Kinney Drugs will handle everything for you!

- ▶ Let us know which prescriptions you would like to include in our *ReadyScripts* service.
- ▶ Complete this form.
- ▶ Drop it off at your preferred Kinney Drugs pharmacy.
- ▶ We will notify you when your prescription is ready!
- ▶ If you run out of refills we will automatically contact your physician for a new prescription.

NAME: _____ **PHONE NUMBER:** _____
 (Print your name as it appears on your Kinney Drugs prescription label) (Where you wish to be contacted)

Please enroll all of my eligible prescriptions in the *ReadyScripts* program

1. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

2. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

3. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

4. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

5. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

6. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

7. **Rx NUMBER**

--	--	--	--	--	--	--	--

 (Print number as it appears on your prescription label)

Medication Name: _____

8. **Rx NUMBER**

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 (Print number as it appears on your prescription label)

Medication Name: _____

*By completing and submitting this form, I am requesting enrollment in the *ReadyScripts* service. I understand prescriptions are not eligible for *ReadyScripts* service if they: 1). Are for controlled substances, 2). Are paid for by Medicare Part B, Worker's compensation or state Medicaid 3). Or fail to meet all eligible refill parameters.*

Patient's Signature: _____ Date: _____