WhidbeyHealth
COMMUNITY PHARMACY

HOME DELIVERY CONSENT FORM

Patient Name: ______________________ **Email :** ______________________

Delivery Address: ____

Home Phone: ______________________ **Mobile Phone:** ______________________

By signing this form, I acknowledge and agree to the following terms and conditions related to the home delivery service provided by WhidbeyHealth Community Pharmacy:

1. **Credit Card Prepayment**
   - I understand that payment for medications must be completed in advance via credit card before the delivery can be made.
   - I authorize WhidbeyHealth Community Pharmacy to charge my credit card for the cost of my medication copay.
2. **Delivery Timeframe**
   - I acknowledge that same-day delivery is not available.
   - I understand that new and refill requests will be processed and delivered within a timeframe of 3 to 5 business days from the date of request.
3. **Delivery Scheduling**
   - I agree to provide accurate and complete delivery information to facilitate a successful delivery.
   - I understand that delivery schedules are subject to availability and may be adjusted as necessary.
4. **Delivery Conditions**
   - I consent to the delivery of my medications to the address provided above.
   - I understand that it is my responsibility to be available to receive the delivery.
   - I understand that all schedule medications require a Government issue ID before receiving and that the courier will not leave the medication unless this is provided at time of delivery.
   - I understand that only medications that have been processed as a valid prescription will qualify for delivery and that delivery does not include items such as OTC medications or supplies.
   - I understand that if no one is home to sign for the delivery, the courier will leave a notice indicating that an attempt was made, and the prescriptions will be returned to the pharmacy. A second attempt will be made the following day.
   - I understand that if no one is available to sign for delivery after two attempts the medications will be returned to the pharmacy and I will be responsible for picking them up.
5. **Confidentiality and Privacy**
   - I acknowledge that WhidbeyHealth Community Pharmacy will take all reasonable steps to ensure the confidentiality and privacy of my medication information during the delivery process.
6. **Contact Information**
   - I agree to provide accurate contact information and notify the pharmacy of any changes to my address or delivery preferences.
7. **Delivery Issues**
   - I agree to notify WhidbeyHealth Community Pharmacy promptly if there are any issues or discrepancies with my delivery.

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined in this consent form. I consent to the delivery of my medications as described above.

Patient Signature: ______________________________ Date: ______________