

NOW SAVE MORE and it's FREE

ReCept Prescription Club™ Enrollment Form

Member Information

Name _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Other family members covered by this membership:

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Please notify me by: mail email do not notify me of health events or special value and promotional offers

Membership Agreement

1. Membership is free. No initiation or annual fees are required. Membership may be for an individual or a family.
2. Family membership includes immediate family only – member, spouse and dependant children.
3. Benefits of membership available only at this location.
4. Member will receive a discount off this pharmacy's usual and customary prescription prices. Amount will vary based on pharmaceutical product dispensed.
5. Member agrees to receive notification (unless specifically declined above) of all health events scheduled by this pharmacy or its affiliated pharmacies and companies, newsletters, special value offers, or other marketing materials on a periodic basis by mail or electronically according to member's preferences.
6. Member's information will not be made available to any organization or company, other than ReCept Healthcare Services and its affiliates.
7. This agreement may be modified at any time without prior notice. Member will receive written or electronic information concerning any changes to this agreement. This information may be provided in writing or electronically.
8. This pharmacy or any of its affiliates will not use member's information for any purposes not described in this agreement.
9. Member should review the pharmacy's Privacy Notice and HIPPA Consent & Acknowledgement form for information or confidentiality and protection of health information.

Signature _____ Date _____

Printed Name: _____