ReadyScript
BY KINNEY

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

Complete this form and drop it off at your preferred Kinney Drugs pharmacy and we will handle the rest! If you run out of refills, we will automatically contact your provider for a new prescription.

☐ *Please enroll all of my eligible prescriptions in the* **Ready**Script *program.*

NAME: _____ **DATE OF BIRTH:** _____

(Print your name as it appears on your Kinney Drugs prescription label.)

MOBILE: _____

(Must be a mobile number.)

By completing and submitting this form, I am requesting enrollment in the **Ready**Script *service. I understand prescriptions are not eligible for* **Ready**Script *service if they: 1) are for controlled substances; and/or, 2) fail to meet all eligible refill parameters. I also understand that if my prescriptions are paid for by Medicare Part B, Worker's Compensation, and/or State Medicaid that I will receive a notification message via text asking for my permission to fill these prescriptions. I acknowledge that if I fail to take action on these notifications, my prescriptions will not be filled until I authorize the fill(s).*

PATIENT OR LEGAL GUARDIAN: _____ **DATE:** _____

Enroll in text message notifications!

Complete the form below and drop it off at your preferred Kinney Drugs pharmacy and we will take care of the rest and notify you when your prescriptions are ready!

☐ *Please enroll in text notifications for updates on my prescriptions.*

NAME: _____ **PHONE:** _____

(Print your name as it appears on your Kinney Drugs prescription label.) (Where you wish to be contacted.)

By completing and submitting this form, I am requesting enrollment in text message notifications. I understand and authorize Kinney Drugs, or a vendor acting on its behalf, to message me about my prescription order(s). I may update my preferences by creating an online account at any time or notifying the pharmacy team to remove my number from notifications. I may also respond "STOP" to the messages and I will be removed from further notifications. I understand I am not required to consent to receive text messages from Kinney Drugs to continue filling prescriptions at its pharmacies.

PATIENT OR LEGAL GUARDIAN: _____ **DATE:** _____

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