Kusler's
COMPOUNDING PHARMACY

700 Avenue D Suite 102
Snohomish, WA 98290
www.kuslers.com
phone: 360·568·1297
Find us on

Kusler's Prescription Auto-Fill Program

Complete and sign form. Send by mail, fax (360-243-3167), or email (Lab@Kuslers.com).

Patient Information:

Name: _____
Address: _____
Phone: _____
Date of Birth: _____
Email: _____

I would like the following prescription(s) to be automatically refilled when it is due.

Rx# _____ Medication & Dose: _____
Rx# _____ Medication & Dose: _____
Rx# _____ Medication & Dose: _____
Rx# _____ Medication & Dose: _____

Pick up or Mail:

☐ Please notify me when my prescription is ready for pick up.
☐ Please ship my prescription.

Credit Card to be charged at time of service:

☐Visa ☐MC ☐Discover ☐Amex
Name as it appears on Card: _____
Card Number: _____
Expiration: _____ V-Code: _____

Courtesy Auto-Fill Policy:

I acknowledge and agree to Kusler's Compounding Pharmacy's Courtesy Auto-Fill policy. I am voluntarily requesting to be placed on this program to improve my health and compliance with my medications. It is my responsibility to notify Kusler's Compounding Pharmacy of any changes in drug dose, or frequency that might affect my medication profile and refill regimen. I acknowledge that should I fail to do any of the above, which may result in an unnecessary fill, it is my financial responsibly. It is my responsibility to notify Kusler's Compounding Pharmacy if I wish to discontinue this service or if my address changes. Notification must be given 3 days prior to prescription being filled in order to avoid financial responsibility for the prescription. Prescriptions may not be returned once they have left the pharmacy.

Printed Name: _____

Signature: _____ Date: _____