

**MT. ROGERS MEDICATION ASSISTANCE PROGRAM  
THROUGH THE BLAND COUNTY MEDICAL CLINIC**

**PATIENT CONTRACT FORM**

**I agree to abide by the following responsibilities and conditions of the program:  
(BE SURE TO INITIAL AFTER EACH)**

I understand I cannot have **any prescription coverage** and I authorize the representative of the program to verify this. I understand that if it is discovered I do have prescription coverage I will be held accountable and immediately terminated from the program. I will be responsible for repayment of any and all medications received while on the program.

\_\_\_\_\_ (initial)

I agree to provide **proof of income** that is legitimate and current upon request and update documentation annually, or as needed by the representative of the indigent medicine program. I authorize any agent of the program to verify the information I provide. This may be done through my bank, Social Security Administration, Veterans Administration, my employer, or any other source from which I receive income. I understand that not providing requested documentation would result in being removed from the program.

\_\_\_\_\_ (initial)

I understand that this is **not a reimbursement program** and that I am solely responsible for any medications I have previously purchased and may need to purchase in the future.

\_\_\_\_\_ (initial)

I agree to **follow the Chronic Care Protocols** established by BCMC (including appropriate labs, EKG and X-Ray) and have a physical exam by a Provider at the clinic every 3 to 6 months depending on my age and medical condition(s). Failure to show up for or to keep timely appointments will prohibit medication being ordered.

\_\_\_\_\_ (initial)

*\*Diabetics- every three months, non-diabetics every six months\**

I understand that there may be **delays in getting my medicine** and that should I run out of my medicine before it is delivered, I am solely responsible for obtaining my medications until they arrive. Additionally, should there be any medications that are unavailable through the program, I understand it is my responsibility to obtain those without reimbursement from the program.

\_\_\_\_\_ (initial)

I agree to promptly notify MAP Coordinator or other agent upon any **changes in my income** or the income of any of those in the household, number of people in the household, insurance coverage, address, phone or any changes in my medication.

\_\_\_\_\_ (initial)

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I understand that **inappropriate behavior** on Bland County Medical Clinic property and/or such behaviors directed to any staff member of the clinic or this program will result in immediate permanent dismissal from this program. This includes foul language, threats of any kind, verbal abuse and unsuitable conduct verbal or otherwise. We will not tolerate being treated with disrespectful spoken or physical actions and acting in such a way will result in charges being filed against you. \_\_\_\_\_ (initial)

I understand that I will be **notified by phone or letter** when my medication is delivered to the clinic and that I am responsible for picking it up or making arrangements to have it picked up within the specified time frame. Medications not picked up will be given out as samples and you will be removed from the program. If medication is delivered to my home I agree to let MAP Coordinator or other agent know as soon as I receive it; I understand that failure to do so will result in being removed from the program. \_\_\_\_\_ (initial)

I authorize any agent of the program to **review my medical chart** as necessary to be able to order correct medications. I also authorize the representative(s) to discuss my medical condition(s) and needs with my provider to ensure correct medications are ordered. \_\_\_\_\_ (initial)

My signature below authorizes Map Coordinator or other agent of the program to **sign my name** on the necessary forms needed to order my medication. The purpose of this is to expedite the ordering process by eliminating the mailing of forms back and forth for signature. \_\_\_\_\_ (initial)

Finally, I understand that neither this program nor the agents of it are in any way guaranteeing or promising medication to me. \_\_\_\_\_ (initial)

I have read (or have had them read to me) and understand the Medication Assistance Program Guidelines and agree to follow all of the above requirements for the duration of any assistance I receive from the indigent medicine program.

\_\_\_\_\_  
Patient SIGNATURE and DATE

\_\_\_\_\_  
PRINTED Name