PACIFIC PSYCHIATRIC
INTERVENTION & WELLNESS CENTERS

Medication Refill Request Form

Date of Request: ____________ **Patient Name:** ____ **Patient DOB:** ____________

Medication #1

Name/Strength/Instructions: ____

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Medication #2

Name/Strength/Instructions: ____

____

Medication #3

Name/Strength/Instructions: ____

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Reason for Medication Refill Request (check appropriate box)

- ❏ Missed last appointment
- ❏ No scheduled appointment
- ❏ Clinic/Pharmacy error
- ❏ Other: ____

Name, address, and phone number of the pharmacy where the prescriptions are to be filled at:

____

All patients review the following items prior to submitting form:

- The fee is $25 *per medication* requested.
- The filling of these prescriptions are done at the clinical discretion of the physician/physician assistant. If prescriptions are denied, or the request is due to a clinic or pharmacy error, the fees will be refunded.
- Medication refill fees and any balances for late-cancel/no-show fees must be paid prior to the request being submitted to the provider.
- Medication refill requests will be addressed by the provider no later than the close of the following business day that the completed form and the proper payment was received.

Credit Card to be used for payment:

Name on Card: __________________________________ Number: _________________________Exp: ___ / ___ CVV: ____

Office Use Only

Fee Collected / Amount: ___________________

Date completed form received: _________________

Medication Filled: YES / NO

Staff Comments: ____

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