



**Gatti Pharmacy Diabetes Club
Membership Application**

Name: _____ Sex: ___M___F
Street Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Email: _____
Birthday: _____ Drug Allergies: _____

What medications do you take?

Please list any diseases you have.

How did you hear about us? (*Please specify*) _____ Do you have a prescription bottle cap preference?
Child-Proof/Safety Easy Off/Non-Safety

Current pharmacy:

Primary Care Provider:

By my signature below, I request membership in the Gatti Pharmacy Diabetes Club. I understand that my enrollment in the program will be automatically renewed after the first 90 days when I make Gatti my pharmacy of choice to fulfill all my prescription needs. I understand that membership in the Gatti Pharmacy Diabetes Club is for my benefit and that this membership can be canceled or changed at the sole discretion of Gatti Pharmacy at any time.

Signature: _____ Date: _____



HIPAA Privacy Acknowledgement

Your signature acknowledges your receipt of our Notice of Privacy Practices (This notice describes how medical information about you may be used and disclosed and how you can get access to this information) and does not acknowledge your Agreement or any restrictions you may request regarding your Protected Health Information.

Signature of Patient, Guardian or Legal Representative

Date