maine family planning

www.mainefamilyplanning.org
www.maineteenhealth.org

Birth Control by Mail Enrollment Form

Name ______________________________ Patient # ______________________

Date of Birth _____/_____/_____

I DO want to enroll in **Birth Control by Mail** (only for patients using birth control pills). I agree the information listed above and below is correct. I understand that it is my responsibility to notify Maine Family Planning (MFP) if there are any changes to this information or if I wish to stop using **Birth Control by Mail**. (Allow 7 business days for any changes or cancellations to take effect.) I understand that **Birth Control by Mail** will stop sending supplies when this prescription expires or all refills have been dispensed.

It is my responsibility to schedule any future exams to renew my prescription as indicated by MFP. MFP requires all enrollees who do not receive fully discounted rates and have a co-pay to provide a valid credit/debit card. Invalid insurance or declined credit/debit cards will result in cancellation of your order.

Patient Signature ______________________________ **Date** ____________________

Shipping Information

- ❒ Address on File
- ❒ Other Address

Street Address ____

City ____________________ State ______________ Zip Code __________

Credit/Debit Card (you must sign the authorization below)

❒ VISA ❒ MasterCard ❒ Discover

Card Number ______________________ Expiration Date __________ CVV Code__________

I authorize Maine Family Planning to automatically bill my credit or debit card monthly/quarterly, until my prescription expires or until this agreement is otherwise terminated.

Cardholder Signature ______________________ Date ______________

Office Use Only

Rx ______________________________ c/u ❑

First shipment due ______________________