



**PHARMACY
REWARDS**

REGISTRATION FORM

Today's Date _____

By law, prescriptions purchased through a Medicare (Part B or D), Medicaid, or government funded programs do NOT qualify for the Acme Pharmacy Rewards program.

FOR OFFICE USE ONLY:

Is the applicant enrolled in Medicare (Part B or D) or Medicaid plan?

CHECK ONE PLEASE:

Yes

No

Pharmacist Initials

ACME SAVINGS CARD NO. _____

**AN ACME FRESH MARKET
SAVINGS CARD IS REQUIRED
FOR PARTICIPATION IN THE . . .**



Name

Address 1

Address 2 Apt. #

City

State

Zip

Phone

Birthdate

E-mail Address

By completing and submitting this form to Acme Pharmacy, I am requesting enrollment in Acme Pharmacy Rewards. I am also authorizing Acme Pharmacy, under HIPAA Privacy Regulations, to provide me with Acme Pharmacy Rewards coupons and promotions.

Signature

Return this completed registration form to your nearest Acme Pharmacy.

All information obtained will remain strictly confidential.