



MAIL-A-PILL REQUEST

Please fill out this application and mail or fax to:

Central Clinic
3850 Beach Blvd
Jacksonville, FL 32207
Phone: (904) 399-2800
Fax: (904) 399-2333

Beaches Clinic
2370-1 South 3rd St
Jacksonville Bch, FL 32250
Phone: (904) 249-2378
Fax: (904) 249-0910

Gainesville Clinic
914 NW 13th St
Gainesville, FL 32601
Phone: 352-377-0881
Fax: (352) 374-6823

Tallahassee Clinic
2121 W Pensacola St
Tallahassee, FL 32304
Phone: 850-574-7455
Fax: (850) 575-4335

Name (please print): _____

Date of birth: _____ Phone number: _____

Mailing address: _____

City/State/Zip: _____

Date I will start my next pack of pills: _____

By signing and submitting this form I understand that:

- This request will ONLY be filled for existing clients with VALID prescriptions on file. PPNF will notify me if my request cannot be processed.
- I have to send in a new Mail-A-Pill form each month to receive my birth control for that month.
- My birth control will be mailed to the address above upon receipt of this completed form by PPNF staff.
- If I have any questions or problems, or if my pills do not arrive on time, I will call my clinic at the number listed above.
- I am ultimately responsible for taking my pills correctly.
- Payment is due at the time of the order.
- Pill Prices: Teen (through age 19): \$17 Adult: \$20
- Patch Prices: Teen (through age 19): \$35 Adult: \$40
- Visa, Discover, MasterCard are only forms of payment accepted. We do not accept checks.

Signature: _____ Date: _____

Cost of pill/patch: \$ _____ # of pills/patches: _____ Total: \$ _____

Name on Card: _____

Card Number: _____

Billing address: _____

City/State/Zip: _____ Expiration Date: _____

Credit Card Authorization Signature: _____ Date: _____

This form is available online at www.ppnfl.org under 'Patient Resources.'