Medication Agreement

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. **If our medical staff at Family Medicine Associates has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.**

1. I agree to follow the dosing schedule prescribed to me by my doctor or APN.
2. I agree to NEVER share my medications with others, nor will I sell or exchange my medications for any reason.
3. I understand there will be NO early refills of any narcotic or controlled medications prescriptions.
4. I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I may have to reschedule.
5. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
6. I understand that abusive behavior or harassment toward any Family Medicine Associates staff will not be tolerated.
7. I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from Family Medicine Associates.
8. I understand that Family Medicine Associates reserves the right to **REQUEST A URINE DRUG SCREEN AT ANY TIME WHEN I AM PRESCRIBED CONTROLLED SUBSTANCES**. If my screen tests positive for un-prescribed substances or negative for medication that I have been prescribed, I understand that this is grounds for dismissal from Family Medicine Associates.
9. I understand that I may be dismissed from Family Medicine Associates if I do not abide by the terms of this medication agreement.

By signing this agreement, I agree that I have the full right and power to be bound by this agreement and that I have read, understood, and accepted these terms.

No medications will be prescribed without the acceptance of this agreement.

_____ _____

Patient/Guardian Signature Date of Birth

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Printed Patient Today's Date