PATIENT AGREEMENT

I,_____, understand and voluntarily agree that
(**Initial** each statement after reviewing):

_____ I will keep and be on time for all of my scheduled appointments with the doctor.

_____ I will take my medication as instructed and not change the way I take it without first discussing it with the doctor.

_____ I will keep the medication safe, secure and out of reach of children. If the medication is lost or stolen, I understand it will not be replaced until the next fill date.

_____ I understand that controlled substances are filled every 30 days only, and they will not be filled early under any circumstances.

_____ I will make sure I have an appointment for refills prior to running out of the medication. I understand it is my responsibility to schedule accordingly. **(Appointment reminders are sent a week prior to scheduled appointments. We do suggest to schedule your follow up at the conclusion of each appointment so you get that advanced reminder and are able to reschedule if needed and still have time to find a different appointment date prior to running out of any medications to stay compliant in treatment plan)**

_____ I will tell the doctor all other medications that I take, and let her know right away if I have a prescription for a new medication.

_____ I will inform the staff of any updates to my insurance, address, pharmacy, email, and/or phone number.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to the staff or doctor, my treatment may be stopped.

_____ I understand that I may lose my right for treatment in this office if I break any part of this agreement.

_____	_____	_____
Patient signature (Parent if patient is a minor)	Patient name printed	Date