ACCESS MEDICAL CLINIC
FAMILY PRACTICE

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.

Please INITIAL each line

_____**Access Medical Clinic** may not prescribe controlled or habit forming medications on my first visit.

_____I agree to follow the dosing schedule prescribed to me by my doctor or APN.

_____I agree to NEVER share my medications with others, nor will I sell or exchange my medications for any reason.

_____I agree to always keep my medications safeguarded and within my control.

_____I understand that I am solely responsible for the safekeeping of my medications. **Access Medical Clinic** will have no obligations to replace LOST OR STOLEN prescriptions or medications.

_____I understand that **Access Medical Clinic** providers have the right to refill or NOT TO REFILL medications prescribed to me by another physician or provider.

_____I agree to use only one pharmacy for my controlled or habit forming medication prescriptions.

_____I understand there will be NO early refills of any narcotic or controlled medications prescriptions.

_____I agree to keep all scheduled appointments. I understand that no medications will be given for cancelled 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.

_____Medication refills will only be available during regular office hours, Monday through Friday from 8:00 am – 5:00 pm. A 48 hour notice is required for all prescription refills.

_____I understand medication refills cannot be made after hours, on the weekends or on holidays.

_____I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.

_____I understand that Access Medical Clinic. 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 **Access Medical Clinic**.

_____I will willingly accept and attend any referral the provider makes on my behalf.

_____I understand long term pain management (chronic pain for more than 6 months) may require a referral to a pain management specialist.

____ I understand controlled or habit forming medications may not have refills. Patients who require monthly prescriptions for these medications may be required to have monthly office visits to evaluate and document their pain and pain control.

____I understand patients may be prescribed pain medication short-term for acute painful injuries such as sprained ankles or lacerations. These medications are for temporary use only and will not be refilled.

I hereby authorize the Providers of **Access Medical Clinic** to access historical prescription drug information. No medications will be prescribed without the acceptance of this agreement.

By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and that I have read, understood, and accepted these terms. I understand that I may be dismissed from **Access Medical Clinic** if I do not abide by the terms of this medication agreement.

_____ _____ _____

Patient Printed Name Patient Signature Date