

MEDICATION CONTRACT

I _____, have agreed to use the following medications as prescribed by the doctor. I understand that I must comply with the following guidelines. I understand that I WILL be terminated from the practice and only 30 days of medication will be given if I fail to follow these guidelines.

- I will follow with the treatment plan that Dr. Wu gives, which includes attending all appointments, adhering to the cancellation policy, and I will also take the medications at the dose and frequency prescribed.
- I will not increase or change how I take my medications without the approval of the doctor.
- I will arrange for refills at the prescribed interval ONLY during my appointment time OR at times given by office. I will not ask for early refills.
- I will obtain all refills for these medications only at
 - _____ (pharmacy)
 - _____ (phone number)with full consent for the doctor and pharmacy to exchange information in writing or verbally. I will also notify office of change of pharmacy.
- I will not request medications prescribed by Dr. Wu from other providers. I understand that if I do Dr. Wu has permission to contact the physicians involved.
- I will protect my prescriptions and medications; I understand that lost or stolen prescriptions will not be replaced with out proper documentation.
- I understand that early refills will not be authorized, and it is up to the discretion of the doctor.

Patient/Parent/Legal Guardian

Date

Witness

Date