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; Being aware that No show, late cancel or arrive late by 5 min, also not adhering to the 24 hr cancellation policy will result in automatic termination.

- I will not increase or change how I take my medications without the approval of the doctor, and I will also take the medications at the dose and frequency prescribed understanding that the office requires a fill of **30 day total interval**.

- I will arrange for refills at the prescribed interval of every _____. I understand that early refills will not be authorized, and it is up to the discretion of the doctor.

- I am to call during office hours to request any prescriptions needed, and are aware if I call outside these hours my prescriptions will not be refilled until the next business day

    - Monday – Wednesday 9am-3pm, and Thursday 9 am-1pm. I will keep in mind any change with Holidays or Dr. Wu being out of the office.

- 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 without proper documentation/ police report.

_____ _____

Patient/Parent/Legal Guardian Date

_____ _____

GERALDINE WU, MD Date