Medication Agreement & Refill Policy

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 1st Choice Healthcare, Inc. has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.**

GENERAL:

1. I am aware that medication refills will only be available during regular office hours, Monday through Friday from 8:00 am – 5:00 pm. I am aware that a **48 hour or two business days**' notice is required to process prescription refills. Please be courteous and do not wait until you are out of medication to call.

2. I agree when I call for a medication refill I will be prepared to give the medication name and strength, such as, milligrams, and the pharmacy phone number.

3. I agree to bring all of my prescribed medications from any doctor's office to 1st Choice Healthcare, Inc. for my office appointments.

4. I understand that the providers at 1st Choice Healthcare, Inc. may choose **NOT TO REFILL** medications prescribed to me by another provider (for example, medications prescribed by psychiatry and pain management).

5. I understand the providers at 1st Choice Healthcare, Inc. may choose **NOT TO PROVIDE** prescriptions for controlled or habit forming medications.

6. I agree to follow the dosing schedule prescribed to me by my provider

7. I agree to **NEVER** share, sell, or exchange my medications with others for any reason.

8. I understand that I am solely responsible for the safekeeping of my prescriptions and medications. I will treat my prescriptions and my medications as I would my money or valuable possessions. I understand that 1st Choice Healthcare, Inc. has no obligation to replace **LOST OR STOLEN** prescriptions or medications.

9. I agree to notify 1st Choice Healthcare, Inc. if I experience any adverse effects or dosage problems with my prescribed medications.

10. I am aware that abusive behavior or harassment toward any 1st Choice Healthcare, Inc.'s staff will not be tolerated.

11. I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from 1st Choice Healthcare, Inc.

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By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and I have read, understood, and accepted these terms. I understand that I may be dismissed from 1st Choice Healthcare, Inc. if I do not abide by the terms of this medication agreement.

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION: I hereby authorize the Providers of 1st Choice Healthcare, Inc. to access historical prescription drug information.

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

1st Choice Healthcare has contracted with local pharmacies which may be able to provide discounts on medications in certain circumstances; however, patients are not required to have their prescriptions filled at those contracted pharmacies. Patients have the right to take their prescriptions to the pharmacy of their choice.

I hereby acknowledge that I have been advised of my right to have my prescription filled at the pharmacy of my choice.

_____ _____

Patient/Guardian Signature **Date**

_____

Printed Patient Name

_____

Pharmacy Name & Phone Number