Mid Cities Psychiatry

Medication Acknowledgement Form

Patient Agreement

I, hereby consent to the following terms for my medication management, underlining my commitments and responsibilities to ensure effective treatment:

Terms Applicable to All Prescriptions:

1. **Appointment Adherence:** I commit to attending all scheduled appointments punctually.
2. **Urine Drug Screening:** I will provide a urine sample upon request within 48 hours. Inconsistent drug screen results with prescribed medications may lead to withholding of further prescriptions.
3. **Financial Responsibility:** I agree to pay all necessary fees at the time of my visits before receiving any services or prescriptions.
4. **Medication Management:** I will securely manage my medication, avoiding sharing, selling, or mishandling. Non-compliance may result in immediate termination of treatment.
5. **Compliance with Treatment Plan:** I will follow the prescribed treatment plan faithfully, engage in all recommended educational programs, and abstain from illegal or disruptive behaviors.

Specific Conditions Based on Medication Type:

- **General Psychiatric Medications:** Per my provider's recommendation, I will maintain regular appointments for continuous prescription management.
- **Attention Deficit Disorder (ADD) Medications:**
  - Routine psychiatric follow-ups as recommended by my provider.
  - Annual cardiac evaluation (EKG) monitored by my primary care physician.
  - Annual health assessment to confirm suitability for continued medication use.
- **Opioid Management with Buprenorphine:**
  - Zero tolerance for intoxication during appointments.
  - Medication dispensed only during scheduled clinic visits.
  - Mandatory disclosure of all other medications obtained from different healthcare providers.

Patient Acknowledgment:

I fully understand the responsibilities and risks associated with my treatment.

I have reviewed and accept the terms of Mid Cities Psychiatry's Practice Policy. I agree to adhere to and be legally bound by these terms.

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