SEVEN HILLS HOSPITAL

Place patient label here

Patient Name: _____

Medical Record #: _____

Medication Contract

I, _____, have been educated and agree to the following rules and conditions regarding prescriptions and/or refills of medications. Seven Hills Hospital will provide you with the medication prescriptions that are needed if you agree to the following guidelines:

1. I am responsible for my medications. If my medication is lost, misplaced, or stolen I understand that they will not be automatically replaced. They may be replaced only at the discretion of my physician or other practitioner.
2. I will strictly adhere to the prescription dosage as recommended by my physician or practitioner.
3. I will not make dosage changes without my practitioner's knowledge and/or consent.
4. I will not give my medications to other people. I will safeguard my prescriptions for personal use only.
5. If my medications are a controlled substance (i.e. Xanax, Adderall, etc.) I realize I must make another medication appointment to have them refilled. I acknowledge that my prescriptions for these medications will not be called into a pharmacy should I lose them, run out, etc.
6. Seven Hills Hospital is not a pharmacy. Samples will not be provided. If you cannot afford a medication that is prescribed to you, your prescribing practitioner will provide you with medication options that you can afford. We will assist you with applications to Patient Assistance Programs through pharmaceutical companies if you are eligible.
7. Pharmacies fax us for a refill authorization when the refills provided by your practitioner have been used. We will no longer be accepting these refill requests that are faxed to us.

   I must schedule and attend a scheduled appointment and have my medication prescriptions filled with my provider.

8. I understand that I cannot call and ask to be put into "Triage" if I have a medication problem (i.e. lost, stolen, run out of medication, etc.).
9. I understand that I must schedule my medication appointments and attend them in order to receive medications. I understand that it is my responsibility to check my supply of medications and schedule the appointment in a timely manner as to avoid running out of medications.
10. I understand that failure to comply with any of these conditions listed above could result in a delay in or termination of medication services from Seven Hills Hospital.

_____ _____

Patient Signature Date

_____ _____

Witnessed By Date

_____ _____

Physician or Provider Date