SRILATHA REDDY, M.D. P.A.
FAMILY HEALTH & WELLNESS CENTER

3600 Conflans Rd.Suite 100
Irving, TX 75061
972-870-0788 ph
972-262-2263 fax

MEDICATION USE AGREEMENT

1._____ understand that I have pain that has not been adequately controlled with other medications and that my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain.

I will take the medication only as prescribed. I will not take sedatives, alcohol or other pain medications without the prior approval of my doctor.

I understand that the medication will be prescribed only by Dr. _____ and only according to the agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone.

I will not seek or accept any medications for pain other than those prescribed by my doctor. "Medications for pain" includes prescriptions from other doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs.

Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working day's notice or two (2) no show appointments may constitute grounds for immediate termination of this agreement.

I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. If I refuse, I understand the medication will be stopped.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen narcotics or narcotic prescriptions.

I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my case and a copy of this agreement when a referral is made.

In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medications from a source other than my doctor.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well being and safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

SRILATHA REDDY, M.D. P.A.
FAMILY HEALTH & WELLNESS CENTER

3600 Conflans Rd.Suite 100
Irving, TX 75061
972-870-0788 ph
972-262-2263 fax

I agree to fill my prescriptions only at the pharmacy listed below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address, and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy of this agreement.

I understand that any alterations in my medication prescriptions will require a new written agreement.

Pharmacy name
_____

Pharmacy address
_____

_____

Pharmacy Telephone
_____

Medication name, dose and directions
_____

Number of pills prescribed _____ Frequency of appointments _____days

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

/ /

/ /

Patient signature Date Physician signature Date