Wolff Center Behavioral Health Medication Management Agreement

The purpose of this form is to ensure a collaborative agreement with The Wolff Center to provide safe and responsible medication management in accordance with ALL government regulatory agencies and policies. This form will be attached to the patients account, and you will be provided with a copy. Please initial beside each statement, indicating you agree to, and understand each.

_____ Some medications require routine blood monitoring. I agree to obtain such lab work as requested by my child's provider. I will inform my child's provider of medications or supplements prescribed by other providers.

_____ I will administer the medication(s) to my child as prescribed & will not change dosage or time without consulting with my child's provider. I will keep medications safe, secure, & out of reach of children. I will NOT share, sell, or trade medications.

_____ ALL MEDICATION CHANGES REQUIRE AN APPOINTMENT. *This includes medication increases, decreases, & boosters.

_____ I understand that if a medication or written prescription is lost, it will not be replaced until the next appointment, appropriate refill time, or may not be replaced at all. I also understand that stolen prescriptions will require a police report in order to be replaced.

_____ Prescription refills should be requested no sooner than one full week (7 days) prior to refill date. *Allow 2 business days to process request. *Afterhours requests are not permitted.

_____ I understand prescription renewals and refills are contingent upon keeping scheduled appointments. ***If a follow-up medication management appointment is missed, I will NOT be approved for a renewal or refill until the next appointment has been completed. *No-show or same day cancellation fee is $25, which must be paid prior to scheduling another appointment.

_____ I understand the importance of keeping scheduled appointments & arriving on time. *Three missed appointments, including same day cancellations, will result in transferring of behavioral services outside of The Wolff Center.

_____ I understand that it is MY responsibility to make sure that I have scheduled my child's next follow-up appointment. Additional prescriptions will not be given due to lack of scheduling in advance.

_____ I understand that all financial obligations must be fulfilled prior to scheduling an appointment. Claims are sent to insurance plans as a courtesy. Non-payment/slow-payment by my health plan is ultimately patient/parent responsibility.

_____ I understand that I may lose my right to treatment at The Wolff Center if I break any part of this agreement.

_____	_____	_____
(Patient Name – PRINT)	(Relationship to Patient)	(Parent/Guardian PRINT)
_____	_____	_____
(Patient Date of Birth)	(Today's Date)	(Parent/Guardian Signature)