Please sign, print, and bring with you to your first appointment.

Medication Management Agreement

This agreement between _____ (patient) and Ageless Medicine of the Palm Beaches (AMPB) establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. AMPB and (patient) agree that these guidelines and conditions are an essential factor in maintaining a successful patient/physician relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

The patient accepts and agrees to the following conditions:

1. I understand that the medical treatment offered by AMPB and their Physician(s) is not accompanied by any claims, guarantees, promises or warranties.
2. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood/lab work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
3. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it's against the law to do so.
4. I will immediately report any adverse side effects related to the use of my medication to AMPB and discontinue use until advised to resume usage by AMPB.
5. I understand that the Physician (MD) and/or Licensed Physician's Assistant (PA-C) are available for questions and/or concerns during normal business hours throughout the course of my treatment.
6. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
7. I agree that these medications are for my personal use only and no other purpose and I will not share, sell, or trade my medications.
8. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.
9. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I agree to contact AMPB 4-6 weeks into the start of my therapy (and every 3 months thereafter) to arrange for any follow-up blood testing and/or an office visit/consultation as required by the AMPB physician.
11. I agree and understand that my fees include a one hundred dollar appointment deposit which will be applied to the cost of my examination, blood work, or therapy. To cancel an appointment, I must email my cancellation request to info@agelessmedicinefl.com at least 48 hours prior to my scheduled appointment time or the $100 deposit will not be refunded.
12. I agree that the AMPB patient/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and my AMPB treatment will be in conjunction with the care provided by my current PCP.

_____
Patient's Signature

_____ _____
Patient's Printed Name Date