Timothy D. Lucey, DO

Board Certified Neurology

MEDICATION AGREEMENT

Unless otherwise noted, the word “physician” or “physicians” as used herein shall mean and refer to Dr. Timothy D. Lucey and any physician employed by Timothy D. Lucey, DO., and PLLC.

I, the undersigned patient, hereby acknowledge that my physician, Dr. Timothy D. Lucey, has prescribed medications for me, which I agree to take in accord with my physician’s advice and/or the information and/or advice received from my pharmacist with respect to the manner in which the medication is to be taken.

I understand there are risks to taking any medication, and such risk cannot be fully stated by my physician; however, I acknowledge being advised by my physician of the major significant risks. I also agree to speak with my pharmacist and read the package inserts for each prescriptive medication my physician prescribes for me. I agree to contact my physician and pharmacist with any questions.

I agree that I only ask for medications from my physician and shall not seek prescriptive medications from another provider without the knowledge of Dr. Timothy D. Lucey. Prior to treatment from any other provider, I agree to inform that provider of my treatment by Dr. Timothy D. Lucey and any prescriptions given by Dr. Timothy D. Lucey for me.

I agree to use only one pharmacy for filling my prescriptions, and will inform Timothy D. Lucey, DO., and PLLC when changing pharmacies.

I agree not to sell or give my personal prescriptions to anyone as this may cause serious injury and/or death.

I agree to inform my doctor immediately if I am pregnant or become pregnant during the course of my treatment. I understand that taking any medication while pregnant can cause injury to my fetus and possible death.

Prescriptions will only be refilled at the Dr.’s discretion. Should a prescription become lost or stolen, it is our policy that a police report must be filed immediately and a copy must be presented to our office.

In the event that I am requested to submit to any random blood or urine tests, I will submit to these tests. I understand that these tests are used for the sole purpose of evaluating my medical condition.

I understand that I must comply with all provisions of this agreement, I further agree that I waive any and all rights to file suits against Timothy D. Lucey, DO., PLLC, for violating any provisions of this agreement. I agree to be solely responsible for all attorney’s fees and costs that my doctor incurs as a result of defending against any suit brought by myself or anyone on my behalf.

I have read (or have had someone read to me) this agreement and I understand the provisions of the Medication Agreement.

_____ _____

Patient’s Signature Date