**Tulsa Rheumatology Clinic**

2622 E 21st Street Suite 1

Tulsa, Ok 74114

P: 918-935-2772

F: 539-867-1681

**Medication Agreement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Tulsa Rheumatology Clinic does not prescribe pain medications for chronic pain. If this is determined to be medically necessary during your treatment, a referral will be placed for you to see pain management.

This is an agreement between you and Tulsa Rheumatology Clinic. You, as the patient must understand that the guidelines listed below are required to continue receiving prescribed medication treatment at Tulsa Rheumatology Clinic.

Along with medication treatment, other medical care may be ordered to help improve your ability to perform daily activities. This may include exercise, physical therapy or other treatments.

I understand that I have the following responsibilities:

**Initial**

\_\_\_\_ I will inform Tulsa Rheumatology Clinic of all medications that I am taking.

\_\_\_\_ I will take medications only at the dose and frequency prescribed. No early refills if medications are overused/abused/misused.

\_\_\_\_ I will not increase or change medication without the approval of Tulsa Rheumatology Clinic.

\_\_\_\_ No refills will be done on Fridays, weekends, after hours, or on observed holidays.

\_\_\_\_ I agree to keep all scheduled appointments and follow all therapies prescribed according to your treatment plan.

\_\_\_\_ New symptoms and or events will require a clinic appointment. Dr Cunningham is unable to diagnose or treat me over the phone.

\_\_\_\_ I will not consume excessive amounts of alcohol in conjunction with certain prescribed medications. If there is a question regarding whether I can consume alcohol, I will call the clinic for clarification.

\_\_\_\_ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff and or disrupt the care of other patients, I may be dismissed from Tulsa Rheumatology Clinic.

I understand that Tulsa Rheumatology Clinic may stop prescribing medications and or change

my treatment plan if:

**Initial:**

\_\_\_\_ I am unable to attend my follow up appointments or if I do not obtain required lab evaluation for monitoring.

\_\_\_\_ My behavior is inconsistent with this signed contract

I understand that failure to adhere to these policies may result in termination from Tulsa Rheumatology Clinic and/or medication prescribed by Dr Cunningham.

I affirm that I have full rights and power to sign and be bound by this agreement with under the

care of Tulsa Rheumatology Clinic, and I accept all of the medication agreement terms above.

Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_