# Serene Minds,LLC

410 Foulk Road, Suite 102
Wilmington, DE 19803

80 Omega Dr. Bldg C
Newark, DE 19713

## Medication Management

### PATIENT TREATMENT AGREEMENT

- I understand that this Agreement is essential to the trust & confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this agreement.
- I understand that if I breach this agreement my physician will be forced to stop prescribing controlled substances, immediately.
- I will not share, sell or trade my medication with anyone.
- I will not seek additional providers to prescribe medications for my mental health.
- I understand that my medications are my responsibility; I will safeguard my medication from "loss" or "theft". I understand that **lost or stolen medications will not be replaced under any circumstances.**
- I understand that such mishandling of my medications is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
- I understand that, unless otherwise specified, I must be seen at least one (1) time every three
    - (3) months. Refills for medication will not be made over the phone if I have not been seen according to advised intervals (monthly/bi-monthly/tri-monthly/etc.) per my prescriber. **No refills will be made during evenings (after hours) or on weekends.**
- I agree to take my medication exactly as prescribed so as to not run out of medication. I understand that use of my medication at a greater rate will result in my being without medication for a period of time. **Our office does not provide early refills for medications; any medication changes must be approved by the doctor.**
- I agree to adhere to the payment policy outlined by this office.
- I agree to conduct myself in a *courteous manner at all times* when in the doctor's office. Inappropriate language or behavior towards administrative or clinical staff will not be tolerated.
- I agree to getting lab work for screening/testing at my provider's request, in a timely manner.
- ***I understand that violation of the above may be grounds for termination from this practice. Serene Minds will make all notifications of termination of care in writing.***
- **I understand that Serene Minds, LLC can withdraw from this agreement at any time.**

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**Signature of Client**

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**Printed Name (Please print clearly)** **Date**