Date_____

Drug Screen Acknowledgement

115 Towne Center Pkwy
Suite 114
Hoschton, GA 30548

P: 706-684-0588
F: 706-684-0753

AnointedHands.Net

Name **DOB**

Please initial next to the appropriate statements below:

☐I acknowledge that my physician may request a drug screen to ensure adherence to documented medical treatment if I am prescribed controlled substances.

☐I consent to this drug screen and accept any consequence that may come as a result.

☐I attest that any urine sample I submit is my own and has not been tampered with.

☐I do NOT consent to this drug screen and I am aware that I will not be prescribed any scheduled medications under any circumstance unless I consent to drug screens.

_____

Self-Pay Patients ONLY

☐I agree to pay the full price of drug screens regardless of the results.

_____

My signature below signifies that I acknowledge and agree to the terms that have been initialed above.

Printed Name

X

Signature **Date**

Please refer to our website, AnointedHands.net, to view our updated policies.