

# Beach Counseling Center LLC

## Patient Medication – Provider Policy

\_\_\_\_\_ Pharmacy \_\_\_\_\_  
Patient Name.                      Date of Birth                      Pharmacy Phone Number \_\_\_\_\_

1. I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. In consideration of that goal and the fact that I may be given medication to help me reach that goal, I agree to help myself by following better health habits: exercise, weight control, avoiding the use of tobacco, alcohol, and illicit drugs. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
2. I understand Beach Counseling Center staff must be treated with respect **AT ALL TIMES.** Abusive language, threats, and harassment will not be tolerated. Failure to observe common courtesy towards our staff may be cause for discharge from the practice.
3. I agree that to comply with suggested treatment modalities, including therapy, AA or other 12 Step Programs like Alcoholics Anonymous and all other prescribed medications, including medications for depression, sleep and neuropathic pain. This also includes psychiatric care, counseling, pain management and family practice follow-ups if needed. Failure to follow the total plan of care may result in discharge from the practice.
  - a. For continuity of care purposes, I give permission for my demographic information to be referred to a collaborating provider outside of BCC, for such use a specialty, PCP, and/or other services needed.
4. Our office will not be responsible for treating certain medical conditions that should be followed by a primary care physician (high blood pressure, diabetes, thyroid problems, etc.). Please see your primary care physician for these issues.
5. Please call the pharmacy to request a refill of a medication from our office. Please allow **3-4 business days** for refills.
6. If you require paperwork to be filled out by our office, please allow 7 business days for this to be completed.

### **IF SCHEDULED MEDICATIONS (STIMULANTS, BENZODIAZEPINES, OPIATES, BARBITUARATES, TRANQUILIZERS, ETC..) ARE INITIATED BY THIS PRACTICE, THE FOLLOWING CONDITIONS WILL APPLY:**

1. **I AM RESPONSIBLE FOR MY SCHEDULED SUBSTANCE MEDICATIONS.** If the prescription or medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced. If this happens repeatedly, I will be discharged from the practice.
2. **I WILL NOT REQUEST OR ACCEPT SCHEDULED SUBSTANCE MEDICATION FROM ANY OTHER PHYSICIAN OR INDIVIDUAL WHILE I AM UNDER THE CARE OF BEACH COUNSELING CENTER FOR PATIENT CARE.** Besides being illegal to do so, it may endanger my health. The only exception is medications prescribed while I am admitted in a hospital, undergoing surgical procedure, or have major dental work performed. In such events, I understand that I am expected to notify Beach Counseling Center staff immediately of the additional prescriptions.
3. I agree to comply with random urine, blood, or breath testing documenting the proper use of my medication as well as confirming compliance. I understand that a random test may be requested, and I am expected to comply within 24 hours. I understand that it is my responsibility to comply with the laws of the state while taking the medication prescribed. A pill count can be requested at any time.

**OVER ⇒**

