

ATTESTATION REGARDING PRESCRIPTIONS

I hereby recognize that I am being prescribed a medication that may be discontinued at any time without notice.

In so doing, I hereby hold Edward Amoah, M.D., P.A., and all practitioners and staff thereof harmless from all medical consequences, addiction, withdrawal, possible DEA investigation, litigation, etc, and I solely and personally accept all risks, liabilities, consequences, and costs.

I and I alone will call for and pick up all such prescriptions/refills.

I will fully comply withal other medical recommendations and follow-up.

I will not increase medications without express written permission and recognize that there will be no early refills regardless of theft, fire, etc.

I recognize that medications cannot be changed until I return the unused portions of prior medications and only at the discretion of Edward Amoah, M.D., P.A.

I hereby attest that I do not and will not use any street drug of any kind.

I will immediately on demand at any time provide and pay for a random blood and/or urine specimen without leaving the office, within a reasonable time frame, and to the sole satisfaction of Edward Amoah, M.D., P.A.

I will not accept without express written permission from Edward Amoah, M.D., P.A. any of the following: pain medications, anti-inflammatory, muscle relaxants, diet pills, sleeping pills, energy pills, or any neurological not psychiatric medications of any kind.

I will use only the following pharmacy for all prescriptions:

Pharmacy _____ Phone _____

Patient _____ Date _____

Signature _____