Advanced Psychiatry & Addictions Specialists
Robert M. Allen D.O.
Board Certified Psychiatrist

PRESCRIPTION POLICY

Refills will only be made during regularly scheduled appointments. Please notify the nurse of what medications that you need refilled and if you require a 30 day or a 90 day prescription. Please bring a list of all your current medications, including those prescribed by other physicians, to each visit so that we may maintain an accurate record of your prescriptions.

Please note that no refills will be done after hours or on the weekend under **any** circumstances. If you need a refill between regularly scheduled appointments please call your pharmacy. The pharmacy will fax a request to our office.

Controlled substances will not be refilled before the date they are due under **any** circumstances. If you need a refill on a controlled substance please call the office to schedule an appointment. Controlled substances will be filled at appointments only.

If you receive controlled substances from other physicians you will be discharged as a patient. Be advised that doctor shopping for controlled substances prescribed for any reason may be considered a federal crime and will result in notification to the proper authorities.

_____ _____
Signature Date

Patient Responsibility Statement

I hereby give permission to Dr. Robert M. Allen to provide me with the psychiatric/psychological evaluation and treatment which is believed to be in my best interest. I understand that I have the right to discuss the plan of treatment with my provider and that my provider will take necessary actions to insure safety for myself and others in the event of an emergency.

I understand I have chosen to seek treatment with a provider who is non-participating with my insurance company, that I am responsible for payment in full at the time of service, and that I am able to request documentation that I may forward onto my insurance for possible reimbursement. In the event my insurance company requests additional information in order to process my claim my signature on this Agreement, authorizes you to provide this requested information to my carrier

I understand that if I cancel an appointment without giving 24 hour notice that I will be personally responsible for the session charge. In addition this office charges $ 25.00 for filling out forms such as disability, family medical leave, etc.

My signature below indicates that I have read and understand the conditions set forth above, in addition that I have been offered to receive a copy of this offices Notice of Privacy Practices (HIPPA) Patient Services Agreement and agree to its terms.

_____ _____
Signature Date