MEDICATION POLICY FOR MINORS

The following policies apply to the minor under Dr. Singh's care. The signatures of the patient and parent/guardian at the end of the form signify acceptance of the policies as written below.

1) I understand that Dr. Singh may recommend medication as part of my treatment plan.

2) I understand that I have a right to comprehend the risks and benefits of taking and not taking medication, and I may ask Dr. Singh for information regarding side effects and other concerns surrounding medication.

3) I understand that I have the right to refuse medication.

4) I understand that I may provide verbal consent to take medication.

5) I understand that by filling a prescription provided by Dr. Singh and taking the medication, I am providing my consent to be treated with medication.

6) I understand that it is my responsibility to take medication only as prescribed by Dr. Singh, and not to adjust the dose or schedule of medication without first discussing it with Dr. Singh and getting his express permission and agreement

7) I understand that it is imperative that I disclose all medications and over the counter formulations I am currently taking, including herbal derivatives and supplements, to Dr. Singh.

8) I understand that not disclosing medications that I take which have addictive potential such as pain killers (opiates), anti-anxiety medications (benzodiazepines), ADHD medications (stimulants), among others is a serious breach of the physician-patient relationship. *I pledge that I will not seek prescriptions from other providers for these types of medications without the prior knowledge and agreement of Dr. Singh.* I understand that violation of this pledge may result in termination of care by Dr. Singh.

9) I understand that non-disclosure of illicit substance use (as well as alcohol use) is also a serious breach of the physician-patient relationship. I understand that this non-disclosure may result in termination of care by Dr. Singh.

_____	_____
Signature of Patient	Signature of Parent/Guardian
_____	_____
Printed Name of Patient	Printed Name of Parent/Guardian
_____	_____
Date	Date

