Medications/Prescriptions Agreement

Patient Name: _____ Date of Birth: _____

I understand and agree to the following regarding prescriptions and medications dispensed by Elite Wellness & Anti-Aging:

I will safeguard my written prescriptions and understand that if I misplace the prescription, another one will not be written until the lost prescription expires or another appointment is made with Dr. Shelton.

I understand that I will have to see Dr. Shelton and/or providers within Elite Wellness & Anti-Aging at least every six months to receive additional prescriptions for medication.

I understand that medications provided by Elite Wellness & Anti-Aging are for my personal use only and for no other purpose. I will not share, sell or trade medications.

I will safeguard my medications from loss or theft and will be responsible for their safekeeping. If I lose, break or misuse prescribed medications, I will not be given more medication until the appropriate date determined by the American Drug Association.

I will only be able to pick up my prescription. I will not be able to send someone else to pick up my prescription or pick up a prescription for someone else.

Elite Wellness & Anti-Aging does not perform Prior Authorizations for insurance coverage on medications.

All medications utilized or sold within Elite Wellness & Anti-Aging include fees associated with medication management/oversite and vary depending on the specific medication.

Elite Wellness & Anti-Aging has the right to dismiss me as a patient at any time if I do not abide by the conditions set forth in this agreement.

Patient/Guardian Signature: _____ Date: _____

Relationship if not the patient: _____