



Please complete and sign both pages and fax to (561) 354-2744

# Medication Management Agreement

This agreement between \_\_\_\_\_ (patient) and Nationwide Synergy, Inc. (NSI) establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. NSI and (patient) agree that these guidelines and conditions are an essential factor in maintaining a successful patient/physician relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

**The patient accepts and agrees to the following conditions:**

1. I understand that the medical treatment offered by NSI and their Physician(s) is not accompanied by any claims, guarantees, promises or warranties.
2. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood/lab work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
3. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it's against the law to do so.
4. I will immediately report any adverse side effects related to the use of my medication to NSI and discontinue use until advised to resume usage by NSI.
5. I understand that the NSI Physician (MD) and/or Licensed Physician's Assistant (PA-C) are available for questions and/or concerns during normal business hours throughout the course of my treatment.
6. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
7. I agree that these medications are for my personal use only and no other purpose and I will not share, sell, or trade my medications.
8. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.
9. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I agree to contact NSI 4-6 weeks into the start of my therapy (and every 6 months thereafter) to arrange for any follow-up blood testing and/or an office visit/consultation as required by the NSI physician.
11. I agree and understand that my fees include a one hundred dollar appointment deposit which will be applied to the cost of my examination and blood work. To cancel an appointment, I must email my cancellation request to DianeV@pbpmed.com at least 48 hours prior to my scheduled appointment time or the \$100 deposit will not be refunded.
12. I agree that the NSI patient/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and my NSI treatment will be in conjunction with the care provided by my current PCP.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date



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## Credit Card Authorization

- Please complete and sign Section A OR Section B.

**A** I authorize Nationwide Synergy, Inc to keep my signature on file and to charge my credit card account, on an ongoing basis for amounts I owe. I understand that this authorization is valid for two years from the below date unless I cancel the authorization through written notice. I also agree to contact the merchant if there are any changes to my credit card account information.

Cardholder Name: \_\_\_\_\_  
FIRST NAME LAST NAME

Cardholder Address: \_\_\_\_\_  
STREET CITY STATE ZIP

If your shipping address is different from your billing address, please enter it here:

Shipping Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Account Number: \_\_\_\_\_  
CARD NUMBER SECURITY CODE EXPIRATION DATE

\_\_\_\_\_ Card Holder Signature \_\_\_\_\_ Date

**OR**

**B** I don't want my signature on file and understand that I will have to provide my complete credit card information every time I make a purchase or reorder my prescriptions.

\_\_\_\_\_ Card Holder Signature \_\_\_\_\_ Date

*Remember, in order to be considered complete, you must fill-out and sign one of the above sections.*