Sheryl M. Hakala, M.D., P.A.

815 South Rome Avenue,
Tampa, Florida 33606
Phone: (813) 503-7404

PATIENT TREATMENT CONTRACT

Patient Name _____ Date ____/_____/_____

As a participant in treatment, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
7. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
8. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
9. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
10. I understand that violations of the above may be grounds for termination of treatment.

_____	_____	____/_____/_____
Signature of Patient	Name of Patient	Date

(Or patient's representative. Please indicate relationship if signing for patient.)