Contract for patients on Patient Assistance Program

1. I understand that the slots for Patient Assistance are limited and highly desired, and I agree to follow the rules of this contract if I am going to have one of these slots.
2. I agree to bring in all paperwork required for these programs in a timely manner. If I am unable to bring in the required paperwork in a timely manner for whatever reason, I understand that I will lose my slot.
3. I agree to pay all fees associated with these programs. This includes the following:
    a. Co-pay for the medication.
    b. Co-pay for the visit.
    c. Charges for any required labwork, including urine drug screens.

    I understand my medication or prescription will not be released until I pay for the above.
4. I agree to comply with all other parts of the treatment program, including the following:
    a. Weekly or monthly visits, as requested by my provider
    b. Weekly or monthly visits with a counselor and/or weekly or monthly group meetings. (My provider and I will discuss which works better for me.)

    If I do not attend these visits, I will be cut off the Patient Assistance Program without a chance to get back on.
5. I need to keep my medication in a safe, secure place. If it is lost or stolen, Patient Assistance Program funds are not available to replace it.
6. The Patient Assistance Program will only last 12 months. It is my responsibility to find other coverage after it expires.

Signed ________________________ (patient) ___________ (date)

Signed ________________________ (provider) __________ (date)