Ziks Health Services
3000 Custer rd. Suite 270
Plano TX 75075
972-972-4850

Medication Consent

1. I agree to take any prescribed medication only after I have had the opportunity to discuss with my provider the potential risks, benefits, and alternatives to each medication, and have received reasonable answers to my questions.

2. I understand that medications/supplements will be selected that have helped treat similar symptoms in others, but this is not a guarantee that they will be effective for me. I will notify my provider about any side effects or problems with any prescribed medications or supplements.

3. I understand that I have the right to withdraw my consent and stop taking the medication(s). If I decide to discontinue the medication(s), I will tell my provider immediately, as some medications should not be discontinued without first reducing the dose.

4. I understand that my provider has the right to discontinue any medication if there is concern that I am not taking them as prescribed or if they are not contributing to my long-term well-being.

5. It is my responsibility to notify my provider of any other medications or supplements that I take, as well as of any drug or alcohol use, as some may not be safe when used together.

6. I understand that it is my responsibility to notify my provider of any changes in my medical status since this could impact the safety of previously prescribed medication(s).

7. I understand that my provider may further verify my medication history by contacting my pharmacy, other providers, or prescription records maintained by my insurance company or the state of Oregon.

8. Females: It is my responsibility to notify my provider if I have any reason to suspect that I am pregnant, or if I am breastfeeding, or planning to become pregnant.

Printed Name _____

Patient Signature _____ Date_____/_____/_____