Divine Health Group

Consent for Medications

Please initial each section below

_____ My medical professional has explained to me the reasons for, and the necessity of use of medication for my treatment plan, the benefits which may be expected from such treatment, and the possible alternative treatments.

_____ I have been provided information via educational conversation, materials, fact sheets, or videos.

_____ I have had the opportunity to ask questions and have them answered regarding my treatment plan and medications prescribed.

_____ I understand the risks involved in taking prescribed medications, and my provider has reviewed indications, medication class, mechanism of action, duration of onset, dosing, interactions, side effects, off label uses, and adverse effects.

_____ I understand that often times medications prescribed may vary from the indication provided on the package insert or those set forth by the FDA also known as “off label”. Off-label prescribing is a common and legal practice in medicine. This practice is justified when scientific evidence suggests the efficacy and safety of a medication for an indication for which it does not have FDA approval and when the practice is supported by expert consensus or practice guidelines. Through shared decision making, I feel an equal partner in the clinical decision-making processes, and have carefully weighed risks and benefits of my current treatment plan.

_____ I understand that medications prescribed may not be covered by my health insurance. Medication charges are my responsibility. As a courtesy, DHG will work diligently with pharmacies and insurance companies to promote coverage of medications. However, if my insurance/payer source reduces the amount or denies the pharmaceutical coverage for any reason, the balance of the medication will be my responsibility.

_____ I agree to voluntarily take medications as prescribed throughout the course of my treatment plan. I agree to inform and discuss discontinuation of medications with my provider.

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Name of authorized individual signing form