HERON RIDGE ASSOCS., PLC

Medication Management Policy

Notice to Clients Receiving Medication

It is the policy of our psychiatric staff that clients receiving medications be seen for medication reviews at a minimum of every 90 days. This policy follows the guidelines of the American Psychiatric Association.
The frequency of your therapy sessions will be determined by you and your psychiatrist/therapist.

Psychiatrist Appointments

We recommend that you schedule your appointments in advance so there is no interruption in your medication. We understand that problems do come up; if you are unable to make your scheduled appointment please call with at least 24 hours notice to cancel your appointment. *We do charge a late cancellation/no show fee of $50.*

Prescription Refills

- There will be a $10 charge for prescriptions needing to be filled in between regularly scheduled appointments, along with a 72 hour processing time. *There will be no charge for the initial request.*
- In addition, it is the client's responsibility to notify us when running low on medication (*within ten days of the need for a refill*) in order to set up an appointment with the psychiatrist before medication has run out. Medications will not be called in or written, without being seen, except in an emergency.
- A $15.00 fee will be charged to patients who chronically lose prescriptions or do not schedule appointments in a timely manner. This fee does not apply if a change is made due to a treatment plan change. *Certain medications cannot be called into the pharmacy; these prescriptions will need to be written.*

Mail Order Prescriptions/Medco

If you use a mail order company for filling your prescriptions please make the doctor aware of your insurance plan policy when he is filling out your prescriptions (some companies require a 3 month supply or have other specific policies). It is the patient's responsibility to mail the prescriptions to the mail order pharmacy. There will be a $5 faxing fee for any prescription faxed directly from our office.

I acknowledge that I have reviewed the medication management policy.
Signature indicates that these terms are understood and agreed to.

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Patient name (please print)

______________________________________ __________________
Patient or Personal Representative Signature (please sign) **Date**