Over-The-Counter Prescription Request Form

Patient Name: ____ Date of Birth: _______________

Patient Address: ____

Please list each over the counter medication for which you would like a prescription. Please note that we charge $10 for each prescription, **but we will waive the fee if you request the prescriptions during a regularly scheduled office visit.**

I agree to pay $10.00 for each over-the-counter prescription provided. I understand the fee will be waived if prescriptions are provided during a regularly scheduled office visit.
SIGNATURE: **DATE**