Restore Mental Health
Medication, Syringe & Payment Receipt Acknowledgment
Medical Weight Management Program

Patient Name: _____ DOB: _____

Today's Date: _____ Provider: _____

Items Received

Medication name	
Strength / concentration	
Quantity / vial(s)	
Syringes / needles received	Quantity: _____ Size: _____
Other supplies	
Dispensing pharmacy (if applicable)	

Patient Acknowledgment

☐ I acknowledge that I have received the medication and supplies listed above, including the syringes/needles indicated.

☐ I acknowledge that I have paid the amount due for the medication and/or related items listed below, subject to any separate written practice refund/cancellation policy.

☐ I have had an opportunity to inspect the items I received and to ask questions about the medication, supplies, storage, and administration.

☐ I understand that I must follow the prescription label and the dosing instructions provided for my specific medication and concentration. I will not estimate or guess a dose.

☐ I understand that needles and syringes are single-use items and must not be shared. I will dispose of used sharps in an appropriate sharp's container according to applicable local requirements.

☐ I understand that signing this acknowledgment confirms receipt and payment; it does not waive my right to contact the practice or pharmacy regarding a medication error, product-quality concern, adverse reaction, or other clinical issue.

Payment Record

Amount Paid: $_____
Payment Method: ___ Cash ___ Card ___ Other: _____

Printed Name: _____

Signature: _____