Arthroscopic Surgery,Sports Medicine,
PRP and Stem Cell Treatments

Alan M. Lazar, M.D., F.A.C.S.
Board Certified by the American Board of Orthopaedic Surgery

MEDICATION CONTRACT

DIRECTIONS: PLEASE READ THE FOLLOWING CAREFULLY AND FILL OUT ACCORDINGLY.

I, ______________________________________, have chosen Dr. Alan M. Lazar,
(Patient Name)
to be the sole practitioner prescribing pain (narcotic) medication to me. I understand that if I choose to obtain pain (narcotic) medication from any other physician, I will be terminated from any future medical care by Dr. Alan M. Lazar.

Patient Signature: _______________________________ Date: ___________

Witness Signature: ____

PLEASE NOTE

If you are receiving pain (narcotic) medication from another physician or choose not to receive any pain medication, please do not sign above. Rather, please circle which applies to you below and sign this form.

Please circle which applies to you:

ALREADY BEING PRESCRIBED *DO NOT WANT TO RECEIVE*

Patient Signature: _______________________________ Date: ___________

Westside Medical Arts • 350 NW 84 Avenue #206 • Plantation, FL 33324
www.dralanlazar.com
Phone: (954) 476-9494 • Fax: (954) 476-8288