



I, \_\_\_\_\_ am taking the following medications:

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I am paying for the above medications with funds from my HSA/MSA/Flex spending account.

Patient Signature: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_  
(if the patient is a minor or unable to sign)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_