SXM SYMPTOM MEDICINE™
Pain Medicine, Palliative Care, Anesthesia

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30 DAY NOTICE OF DISCONTINUATION OF SERVICES

Date		
Patient Name:	Address	Tel
PCP	Address	Fax
		Tel
Referring M.D.	Address	Tel
		Fax

Dear

As a result of acting against the advice of the treating physician and Symptom Medicine Clinic rules and policies, it is necessary to discontinue all of your medical services at Symptom Medicine. As agreed in your Terms and Condition of Service, you will continue all of your medical care with your primary care physician. During your final 30 days at the clinic, Symptom Medicine will provide you with two to four weeks supply of the medications prescribed by SXM. Thereafter, you will continue all of your care with your referring physician and primary care physician.

I, the undersigned, acknowledge that I have been informed of the above, and hereby release the treating facility physician and Symptom Medicine from any liability. And acknowledge that the last day of service at Symptom Medicine will be ___________________.

Patient Signature	Name	Date and Time
Patient Representative Signature	Name and Relationship	Date and Time
Witness Signature	Name	Date and Time

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