



Medication agreement & refill policy

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. **If Consultants in Pain Medicine has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.**

1. I agree to follow the dosing schedule prescribed to me by my doctor or PA.
2. I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.
3. I agree to always keep my medications safeguarded and within my control.
4. I agree to notify Consultants in Pain Medicine if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medication. Before any new medication can be prescribed, I may be asked to bring any unused medication to Consultants in Pain Medicine for disposal.
5. I agree that if I receive narcotic prescriptions from Consultants in Pain Medicine, I am not allowed to receive the same type of medications from another physician without express consent or consultation with Consultants in Pain Medicine.
6. I agree to use only one pharmacy for my pain-related medication unless extenuating circumstances prevent this from being possible. In this event, I will notify Consultants in Pain Medicine of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.
7. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled office visit when my doctor is on duty in the office. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone.**
8. **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than 30 minutes late to my scheduled appointment time, I will have to reschedule.
9. I understand that medication refills cannot be made after hours, on the weekends, or on holidays. Consultants in Pain Medicine's phone triage hours are 1:00pm to 4:00pm, Monday, Tuesday, and Thursday.
10. I agree to bring all of my prescribed medications from any doctor's office to Consultants in Pain Medicine for my office appointments. I understand that pill counts may be necessary for controlled substances.
11. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
12. I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Consultants in Pain Medicine will have no obligation to replace LOST OR STOLEN prescriptions or medications.
13. I understand that my therapy at Consultants in Pain Medicine may require a monthly office visit so my doctor can properly evaluate my progress, and/or adjust appropriate narcotic pain medications every thirty (30) days.
14. I understand that abusive behavior or harassment toward any Consultants in Pain Medicine's staff will not be tolerated. Harassment includes, but is not limited to, more than two (2) phone calls to the office in one business day.
15. I understand that I cannot present to Consultants in Pain Medicine unannounced seeking medication refills.
16. I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from Consultants in Pain Medicine.
17. I understand that I may be dismissed from Consultants in Pain Medicine if I do not abide by the terms of this medication agreement.
18. I understand that Consultants in Pain Medicine will not prescribe narcotic medications on my first office visit.
19. I understand that Consultants in Pain Medicine reserves the right to REQUEST A URINE DRUG SCREEN AT ANY TIME WHEN PRESCRIBED CONTROLLED SUBSTANCES. If my screen tests positive for un-prescribed substances or negative for medication that I have been prescribed, I understand that this is grounds for dismissal from the practice. By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. No medications will be prescribed without the acceptance of this agreement.

Pharmacy Name

Pharmacy Phone Number

Patient's Signature

Date

Print patient's name _____