Medication Agreement and Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. As you know, 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 the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed to me by my doctor.
2. I will <u>never</u> share, sell or exchange my medications with anyone for any reason.
3. I understand that I am <u>*solely*</u> responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that <u>Physician Pain Management does not replace LOST OR STOLEN prescriptions or controlled medications.</u>
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
5. I agree to notify Physician Pain Management if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to the office for disposal.
6. I agree that if I receive a controlled substance prescription from Physician Pain Management, I am <u>not</u> allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7. I agree to use only <u>one</u> pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify Physician Pain Management of this immediately and provide them with all pertinent contact information. I authorize Physician Pain Management to access my full prescription history at pharmacies or by electronic means at any time.
8. I understand that medication refill prescriptions involving narcotic pain medicine require a <u>scheduled</u> appointment with Dr. Rubin. **Narcotic pain medication refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.**
9. **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 **15** minutes late to my scheduled appointment time, I may have to reschedule for another time.
10. I know that I can not be seen at the office without a scheduled appointment <u>*for ANY reason.*</u>
11. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
12. I understand that Physician Pain Management will write and dispense narcotic medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
13. I understand that abusive behavior or harassment toward any staff will not be tolerated. If Dr. Rubin determines at his sole discretion that this has occurred on a case-by-case basis, I can be dismissed from the practice.
14. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from Physician Pain Management.
15. I understand that I may suffer withdrawal effects possibly even requiring hospital detox if I violate this contract and am dismissed from the practice.
16. <u>I understand that URINE DRUG SCREENS MAY BE PERFORMED AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If I refuse a drug test, or if tested, the results do not reflect the medicine prescribed by my doctor,or test positive for illegal or non prescribed drugs, I understand that I can be dismissed immediately from the practice.</u>

By signing this 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. Non-compliance with this agreement will be grounds for immediate dismissal from the practice.

_______________________________	_______________________
PHARMACY NAME	**PHARMACY PHONE NUMBER**
_______________________________	_______________________
PATIENT NAME **<u>*Please Print</u>**	**DATE**
_______________________________	
SIGNATURE	