

Patient Name: Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial**\_\_\_\_\_\_**

**Prescription Policy**

The purpose of this policy is to prevent misunderstandings regarding prescription medications you may be prescribed. The medications may be prescribed for pain resulting from an injury or surgical procedure. This policy is to help you and our providers comply with the law regarding controlled pharmaceuticals.

Our office is unable to provide pain medication after business hours and on weekends. Exceptions are made on a case by case basis. **Prescription refill requests require at least 48 hours notice**. Refills will only be called in to the pharmacy listed unless otherwise notified. Please make the necessary arrangements during our regular office hours. Evidence of altering prescriptions, multiple physicians prescribing, or the use of street drugs will result in dismissal as a patient of Bowling Orthopaedics.

* I will not lose my prescriptions as lost prescriptions will not be replaced
* I will take my medications as prescribed. If I use my medication at a greater rate than prescribed, it wil result in me being without medication for a period of time.
* I will not take other medications that may interact with narcotics without first consulting with our providers or their assistants.
* I will not sell, share or permit others to have access to my medications. I will not take someone else’s medication.
* I will not drive or operate machinery while on pain medication because it can alter my mental status.
* I will not drink alcohol while taking these medications because combining these drugs with alcohol may cause severe drowsiness, low blood pressure or even death.
* I will report signs of dependence to narcotics, such as taking increased amounts or taking more often than ordered.
* I will submit to blood and/or urine drug screen testing if requested by Bowling Orthopaedics
* I agree to authorize the doctor and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state’s Board of Pharmacy, in the investigation of any possible misuse, sale, etc. of my medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.
* I will keep al m scheduled appointments. If I need to reschedule my appointment, I will do so a minimum of 24 hours in advance. If I miss an appointment, I will not be able to get a prescription refill and may be charged a $25.00 “no show” fee.
* If I give permission to someone else to pick up my prescription from the office, a photo ID is required and I am responsible if it is lost, stolen, destroyed or does not reach my possession.

I understand Bowling Orthoapedics may stop prescribing the medications if:

* I do not follow the above policies
* I do not show any improvement in pain or my activity level has not improved
* I develop rapid tolerance or loss of improvement from the treatment
* I develop significant side effects from the medication
* My behavior is inconsistent with the responsibilities outlined above, which may result in being prevented from receiving further care from Bowling Orthopaedics.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_