

**Medication Agreement & Refill Policy**

In the course of your treatment you may be prescribed medication by our medical providers. Medications allow our providers to improve your health, but serious side effects may arise if certain of these medications are not managed properly. Our first priority is your health and safety. To this end, our medical providers have established guidelines and policies for your safety. **Our medical providers reserve the right to contact your other treating physicians and pharmacies regarding your healthcare, including medication. Below are the aforementioned polices and guidelines:**

1. I understand that medication refills will only be available during regular office hours. Prescription refills

require a 48 hour notice, so we ask that you do not wait until you have run out of your medication before you contact our office.

1. I understand that medication refills WILL NOT be made after hours, on the weekends, or on holidays.
2. I understand that my medical providers have the right to refill or NOT refill medications prescribed to me

by another medical provider.

1. I agree to provide detailed information about my medication when I request medication refills (I.E.

medication name, dosage, name of pharmacy, etc.)

1. I understand that I may not be prescribed narcotic or habit forming medication at my first visit.
2. I agree to follow the dosing schedule as prescribed to me by my medical provider.
3. I agree to NEVER share medications prescribed to me as a patient with any other person
4. I agree to NEVER sell, exchange, or trade my medications for any reason.
5. I understand that the safeguard and safekeeping of my medications is my responsibility. My medical

provider will not be obligated or required to replace LOST OR STOLEN prescriptions or medications.

1. I agree to contact my medical provider if I experience any adverse effects or dosage problems with

my prescription medications.

1. I agree and understand that I will not be allowed to receive narcotic or controlled medication prescriptions

from my medical provider if I am also receiving similar medication prescriptions from another medical

provider. Only after the express consent or consultation of my medical provider will this be authorized.

1. I understand narcotic or controlled medication prescriptions will NEVER be filled early.
2. I understand and agree to use only one pharmacy for my narcotic or controlled medication prescriptions.
3. I agree to keep on all scheduled appointments and I understand that if I am 15 minutes late or later for my

scheduled appointment time, I may have to reschedule.

1. I agree that NO medication will be given for cancelled or no-show appointments.
2. I agree to bring all my prescribed medications or provide an accurate list of current prescribed medication

at each office visit.

1. I understand that I should not drive or operate heavy machinery while taking medications that may cause

drowsiness or impaired cognitive function.

1. I agree and understand that abusive behavior or harassment toward the staff of Antonio A. Flores, MD PA

will not be tolerated or acceptable.

1. I understand that if I forge, copy, or falsify prescriptions I will immediately be fired as a patient from

Antonio A. Flores, MD PA.

1. I understand that I will be dismissed as a patient if I violate the policies of this agreement.
2. I understand that Antonio A. Flores, MD PA reserves the right to REQUEST A DRUG SCREEN BY

URINE IF I AM PRESCRIBED CONTROLLED SUBSTANCES. If my drug screening tests show positive for un-prescribed substances or negative for medications I have been prescribed, I understand I will be dismissed as a patient from Antonio A. Flores, MD PA.

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 **Patient Signature and Date**

**Chronic Pain & Narcotics**

1. I understand that patients requiring long term pain management, over six (6) months, will require a referral to a pain management specialist. Certain diagnoses may be exempt for this requirement on a case by case basis.
2. I understand that if I am unwilling to see a pain management specialist when referred by my medical provider, I will only be prescribed non-narcotic pain management.
3. I understand that all patients with chronic pain must undergo testing to determine the source of the pain. Chronic pain without objective findings (positive tests) will not be prescribed narcotics.
4. I understand controlled, scheduled, and triplicate medications do not have refills and all patients who require prescription refills for these medications must be seen by a medical provider evaluation and documentation of their pain every three (3) months.
5. I understand that I will be required to present photo identification and sign before my triplicate prescription will be released to me. Triplicate prescriptions will only be released to the patient with the exception of nursing home residents.
6. I understand that Fibromyalgia will not be treated with narcotic pain medications.
7. I understand patients may be prescribed pain medications for short-term acute injuries (I.E. back sprain.) The prescribed medication will be for temporary use and will NOT be refilled.
8. I understand that scheduled and controlled medications can become highly addictive if abused, misused, or not taken as directed by my medical provider.
9. I understand that all patients currently receiving pain medication and who refuse to comply with this agreement and its policies will be weaned off narcotic pain medications

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 **Patient Signature and Date**