Family Foot & Ankle Specialists

# Patient Medication Agreement

For appropriate management of you medication there must be a working relationship between you and you administrative physician. Prior to the initiation and prescribing of medication, we require that after you read this document and ask any questions concerning you medication, you sign this document.

I agree to adhere to the following policies regarding my medications:

1. A single physician prescribes pain medication and a single pharmacy provides medication. If multiple prescribers are being used, you must tell your physician up front so we may prescribe accordingly.

2. Random drug testing is done on all patients that receive narcotic medication. If you refuse a drug test at any time your narcotic medication **WILL NOT** be filled. If your drug test shows any results outside of the expected positive results your narcotic medication **WILL NOT** be filled.

2. Lost, missing or stolen medication **WILL NOT** be made up. If narcotic medications are stolen, a police report is required.

3. Prescriptions will not be issued early, as medications are to be taken as prescribed. If you feel medication changes are needed, these changes must be discussed and approved by your physician.

4. Refill requests for narcotic medication are filled Monday - Thursday 9:00am - 4:00pm and Friday 9:00am - 12:00pm. You **MUST** give your physician **48 hours to refill your narcotic prescription**. Narcotics are now written on a special triplicate form and cannot be called in. Since our doctors travel to a different office each day of the week, it is important to give them ample time to write the Rx and have it at the office of your choice to pick up.

5. Do not abruptly stop taking any medication without advice from your physician. Your physician may recommend detoxification from narcotic pain medications as narcotics are not generally beneficial in treatment of chronic pain.

6. Your physician may decline refills or recommend termination of your doctor-patient relationship if these stipulations are not met or if trust is breached.

7. Your medication will be filled only at the following pharmacy (please include city and phone number):

_____

I acknowledge, accept, and agree to these terms.

_____ _____

Patient Signature Nurse Initials

_____ _____

Printed Name Date