

Prescription and Medication History Policy

Our providers prescribe sufficient medication to last until the next visit and therefore requests for refills are generally not expected. As a general rule, our office does not call in prescriptions for patients. Our providers expect to see patients to be sure the prescription is appropriate, to discuss side effects, etc. If an appointment is rescheduled or missed and medication is required, we charge a \$50 prescription call in fee. This fee is not covered by insurance and must be paid by the patient before any services are rendered. Please allow 24 hours for medications to be called in. While we strive to handle all requests as soon as possible, medication requests require the signature of the ordering physician and therefore there may be a delay in processing.

It is your responsibility to schedule an appointment before you run out of medication. You should schedule your next visit before you leave our office.

Before you come to your regular appointment, you should look over your medications to determine if you need to request any new prescriptions at your appointment. It is very important to request your prescriptions during your office visit.

We do require office visits on a regular basis for all patients taking prescription medication. The interval will vary depending on the provider's discretion and the type of medication prescribed. Please be sure you have enough medication to last until your next scheduled visit.

It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations are detrimental to your treatment. Our office will not provide call-ins more than three times per year.

We will continue to take the time to carefully review your medications and write refills at your office visit. We will also review the prescriptions with you to make sure that they are written correctly.

Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit.

New symptoms or events require an appointment. Your provider will not diagnose or treat over the phone. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.

Sometimes your insurance company will not pay for the medications that our providers prescribe. When this happens, you have three options:

1. We can send the prescription to a specialty pharmacy that will work with your insurance company to get the medicine approved via prior authorization.
2. Your insurance company has a list of medicines that they will cover. This list is called a formulary. We can try to identify equally safe and effective, but cheaper formulary alternatives to any high-cost medicines we prescribe.
3. You can pay out of pocket for the medicine at your preferred pharmacy.

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I understand that my healthcare provider will obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient: [PatientName]

Patient or Guardian Signature: [RequiredSignature]

Date: [CurrentDate]

Controlled Substance Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

1. I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.
2. I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.
3. I understand that if I break this Agreement, my provider will stop prescribing these controlled medicines.
4. In this case, my provider will taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
5. I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.
6. I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.
7. I will not share my medication with anyone.
8. I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.
9. I will safeguard my medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.
10. I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
11. I agree to use the pharmacy on file with Beal Wellness for filling my prescriptions for all of my controlled medications.
12. I authorize the provider and my 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, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
13. I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of my controlled medications.
14. I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.

15. I agree that I will use my medications at a rate no greater than the prescribed rate and that use of my medications at a greater rate will result in my being without medication for a period of time.

16. I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request.

Patient or Guardian Signature: [RequiredSignature]

Patient or Guardian Signature: [PatientName]

[CurrentDate]