



Prescription Refill Policy

Please read the following prescription refill policy carefully and sign below.

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 3 pm will not be received until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I may not change the dosage or alter the time to take the medication without first speaking to my physician.
5. I must keep all appointments as recommended, so that prescription medication can be monitored.
6. I will not give, trade or sell medications.
7. I will not alter or forge a prescription. This is a felony and will be reported
8. I will not combine any narcotic medications with the consumption of alcohol.
9. My pharmacy's name and location is:

_____ Pharmacy Phone # _____

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe pain medications to me.

Patient Name _____

Patient Signature _____ Date _____