Piedmont Spine and Neurosurgical Group, PA

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PRESCRIPTION POLICY

In an effort to provide our patients with the highest quality care, our practice abides by the following prescription policy:

Controlled substance medications are very useful in pain management, but have a small potential for misuse, and therefore are closely controlled by local state and federal authorities. It is essential that you take controlled substances as prescribed. After your physician at Piedmont Spine and Neurosurgical Group, PA has released you from care following your surgery, **prescriptions will no longer be provided.**

1. **NO PRESCRIPTIONS WILL BE FILLED EARLY. YOU**, the patient, are responsible for keeping track of medication, and taking it as the dose and frequency are prescribed.

2. **Prescriptions Will Not Be Refilled if Lost or Stolen** – even if a police report is provided

3. **While a patient at Piedmont Spine and Neurosurgical Group, PA, I agree to obtain all pain medications (narcotics) from the physician treating me at this facility**. I agree that I **Will Not** call a family physician or any other physician to prescribe pain medications.

4. **Our office needs 2 days notice for refills**. Request for medications must be called in by 12:00pm. These will be called in by the end of the day. Request after 12:00pm will be called in the next working day.

5. If you miss your scheduled appointment, medications **Will Not** be called in for you.

Please list the pharmacy where you prefer your prescriptions called:

Pharmacy: _____

Phone Number: _____

*****We will need a new signed Prescription Policy if you wish to switch pharmacies*****

Patients who do not comply with the guidelines of the Prescription Policy of Piedmont Spine and Neurosurgical Group, PA will have their treatment of pain medications discontinued, and may be dismissed from our care.

I acknowledge by my signature that I have read and agree to the Prescription Policy of Piedmont Spine and Neurosurgical Group, PA. I understand if I do not follow the rules of the Prescription Policy, my treating physician may stop my medications or discharge me from the practice.

_____ _____

Patient Signature ***Date***

_____ _____

Witness ***Date***