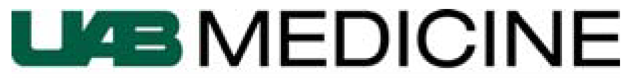

UAB Neurology and Pain Medicine Treatment Agreement & Refill Policy

As part of your treatment, you may be prescribed medications. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follow the prescribed guidelines.

Please read the following and indicate your agreement by initialing each statement and signing at the bottom.

1. I agree to follow the dosing schedule prescribed to me by my doctor. _____
2. I will never share, sell, or exchange my medications with anyone for any reason. _____
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that lost or stolen prescriptions or controlled medication can and will not be replaced for any reason. _____
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function. _____
5. I agree to notify the clinic if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medications for counting and disposal. _____
6. I agree to use only one pharmacy for my pain related medications. In the event that circumstances require the use of another pharmacy, I will notify the clinic immediately and provide all pertinent contact information. _____
7. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled clinic appointment. Narcotic pain medication refills can and will not be called into a pharmacy. Narcotic dosages will not be increased by phone. _____
8. I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments. _____
9. I know that I cannot be seen at the office without a scheduled appointment for any reason. _____

10. Clinic hours are 8:00 a.m. to 4:30 p.m. Monday thru Thursday and 8:00 a.m. to Noon on Friday. The answering machine is available for non-emergency mediation questions and refill requests. I understand that I am not allowed to call this line more than two times in any day. _____
11. I know that I can be asked to bring any or all of my prescribed medication to the clinic either at my regular appointment, or at a random time for a pill count. _____
12. I understand that narcotic medication prescriptions are written on a 30 day basis. In order to receive another prescription, I must schedule another office visit. _____
13. I understand that abusive behavior or harassment toward any clinic staff cannot be tolerated. What actions can be considered harassment will be determined on a case by case basis and, if warranted, I can be dismissed form the practice. _____
14. I understand that dealing with a forged, falsified, or altered prescription will result in my immediate dismissal from the clinic. _____
15. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I have informed my doctor of my past drug usages including narcotics and alcohol and any problems associated with this use. _____
16. I understand that urine drug screens are a part of chronic pain management and may be done at any time while I am being treated with controlled substances. If the results of the urine drug screen do not reflect my prescribed medicine or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice. _____
17. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medicine, and I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the event of any possible misuse, sale or other diversion of pain control medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. _____
18. I understand that the clinic will be checking the Alabama Prescription Drug Monitoring Database in order to detect instances of "doctor shopping", or forged or duplicated prescriptions. _____
19. By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice. _____

Pharmacy Name:____

Pharmacy Contact Number: ____

Patient Printed Name: ____

Patient Signature: ____

Date: ____