

PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

Narcotic pain medication will be given only for a 2 week post operative period and on occasion pre-operatively. Pain medication will only be given for acute **SHORT TERM** pain. If you are suffering from chronic pain we will be happy to assist you in locating a pain management specialist.

1. I agree to allow **48 hours** for prescription refills.
2. I understand that prescription refills requested after **2:00 PM** may not be received and/or called in to your pharmacy until the next **BUSINESS** day. Prescriptions cannot be refilled on Friday, Saturday or Sunday so it is your responsibility to call **PRIOR to 2:00p.m. on Thursday.**
3. I understand that a follow-up visit may be required from Dr. Wells in order to obtain a refill.
4. I agree to take all medication **EXACTLY** as prescribed by Dr Wells. I am **NOT** allowed to change the dosage or alter the time schedule without first speaking to Dr Wells or his nurse.
5. Prescription medication **WILL NOT** be refilled after business hours or on the weekends. Our office is closed on Friday, so you will need to contact the office before Thursday 2:00pm to obtain a refill.
6. Patients may be terminated from the practice without notice for noncompliance in taking of their medication, obtaining narcotics from any other physician while under the care of Dr. Wells or altering or forging of a prescription. **THIS IS A FELONY AND WILL BE REPORTED.**
7. Atlas Orthopaedics **WILL NOT** refill prescriptions that have been lost or misplaced.
8. I understand that I must keep all scheduled appointments as recommended by Dr Wells.
9. I will not combine any narcotic medication with the consumption of alcohol.
10. Only one pharmacy may be used for filling prescriptions prescribed by Dr Wells.

My pharmacy is: _____ phone number is: _____

YOU MUST NOTIFY OUR OFFICE IF YOU CHANGE PHARMACY

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

Patient Name: _____ Date: _____

Patient Signature: _____