Pinnacle
Pain Medicine

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Primary Care Physician_____

Patient's Full Name: _____ □ Mr. □Mrs. □ Miss □ Ms.

Marital Status (Circle One) Single / Mar / Div / Sep /Widow

Birth Date: _____ Age: _____ Race: _____ Sex: M / F

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Social Security:_____

Please list two confidential numbers we are able to leave messages to:

Cell Phone No: (_____)_____ Other Phone No: (_____)_____

E- Mail: _____

Work Status: Retired / Unemployed / Student / Full Time / Part Time: Patient Occupation: _____

Patient Employer: _____ Employer Phone No. (_____)_____

Employer's Address: _____City: _____State: _____ ZIP Code: _____

Is this patient covered by insurance? □ Yes □ No

Name of Primary Insurance (if applicable): _____

Policy # _____Group # _____Co-Payment$ _____

Subscriber's Name: _____ Subscriber's S.S. # _____ Birth Date ___/___ /___

Patient's Relationship to Subscriber □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance (if applicable): _____

Policy # _____Group # _____Co-Payment$ _____

Subscriber's Name: _____ Subscriber's S.S. # _____ Birth Date ___/___ /___

Patient's Relationship to Subscriber □ Self □ Spouse □ Child □ other _____

Is this a Workers' Compensation Injury? □ Yes □ No

Adjuster Name: Adjuster Phone: (_____) _____

If W/C, claim #: _____ Date of injury: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone No.(___)____-_____

Name of Local Friend or Relative (not living at same address): _____

Relationship to Patient: _____ Home Phone No.(_____) ____- _____

____ the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pinnacle Pain Medicine or insurance company to release any information required to process my claims.

____ Pinnacle provides the opportunity for patients to communicate by email. By providing an electronic mail address to Pinnacle, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Pinnacle cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Pinnacle's intentional misconduct.

_____

PATIENT/GUARDIAN SIGNATURE DATE

Pinnacle
Pain Medicine

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION - PLEASE REVIEW IT CAREFULLY

Pinnacle Anesthesia Consultants, P.A., Pinnacle Consultants, L.P. ("Pinnacle") and Pinnacle Pain Medicine are affiliated entities that have entered into an Organized Health Care Arrangement and are jointly issuing this Notice of Privacy Practices about the information we share in common and your legal rights and our common duties with respect to your health information.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which Pinnacle may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Pinnacle doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care **treatment** or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Pinnacle may use and disclose health information about you to obtain **payment** for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Pinnacle may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patients under that guarantor.

Pinnacle may use and disclose health information about you to support our health care **operations**. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are. We may disclose information to notify **a family member or other person responsible for your care** about your condition, status, and location.

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a **patient directory** and make this information available to anyone who asks for you by name.

We may use and disclose health information to contact you for an **appointment reminder**, to tell you about **health-related services** or recommend **possible treatment options or alternatives** that may be of interest to you, or to contact you about supporting **our fundraising** (of which you have the right to opt out) efforts.

Subject to certain requirements, we may use or disclose health information about you **without your prior authorization** for other reasons:

We may give out health information about you for **public health** purposes; to **report abuse or neglect**; for **health oversight reviews**; in **research** studies; for **funeral arrangements** and **organ donation**; in response to special **law enforcement** requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for **workers' compensation** purposes; to **avert a serious threat** to your health or safety or those of the public or another person; and when **required by law**. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice (i.e. psychotherapy notes, marketing, remuneration), we will ask for your written **authorization** before using or disclosing your health information. You may **revoke** this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to request in writing that you **inspect and obtain a copy** of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by Pinnacle will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to **amend information**. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with who we disclose information as previously stated.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

You have the right to make a written request for a **list of disclosures** we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to **request a restriction** on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. ***We are not required to agree to your request for restrictions*** if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for a healthcare item or service in full, out-of-pocket, we must honor your request to restrict the information that is disclosed to a health plan for purposes of payment or operations.

You have the right to request, in writing without requiring you to state a reason, that **confidential communications** with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to be notified of a breach of unsecured PHI in the event that you are affected.

WRITTEN REQUESTS

If you have any questions about this notice, please contact: Pinnacle Partners In Medicine, to the attention of the Privacy Officer at 13737 Noel Road, Suite 1400, Dallas, Texas, 75240 or call (972) 715-5000.

COPIES OF NOTICE AND CHANGES

You have the right to obtain a paper copy of this notice at any time.

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact Pinnacle's Privacy Officer at 13737 Noel Road, Suite 1400, Dallas, Texas, or call (972) 715-5000. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

Please sign the attached acknowledgement that you have received our Notice of Privacy Practices, effective September 23, 2013.

Pinnacle
Pain Medicine

Acknowledgement of Receipt of Notice of Privacy Practices
Pinnacle Anesthesia Consultants, P.A.
Pinnacle Consultants, L.P., Pinnacle Pain Medicine

I received a copy of the Notice of Privacy Practices from the above noted entities.

Signature:_____ Date: _____

Print Name:_____

Personal Representative:_____

If personal representative, please note relationship to patient: _____

Prescription Pick-up Authorization

If you would like to give consent for another individual to pick up your prescriptions or documentations, please provide that name below:

_____

I give consent for my provider to discuss my medical care with the persons listed below.

Name: _____ Relationship:_____

Signature:_____
(*Authorized Representative must present valid photo ID upon pick up*)

Name: _____ Relationship:_____

Signature:_____
(*Authorized Representative must present valid photo ID upon pick up*)

FOR OFFICE USE ONLY

By:_____ Date:_____

Pinnacle
Pain Medicine

PATIENT RESPONSIBILITIES

To better serve you and maintain a professional environment, Pinnacle Pain Medicine has established guidelines to outline patient responsibilities. The guidelines have been established so that our patients can fully benefit from treatment received in our clinic. Your responsibilities as a patient of our clinic are as follows:

1. Please arrive at least 15 minutes (30 minutes on your first visit) prior to your appointment time for clinic appointments in order to take care of any insurance issues or required paperwork. If you are late 15 minutes or more from your appointment time and/or your initial paperwork has not been completed by your appointment time, your appointment will be rescheduled.

2. We require at least 24 hours notice for cancellations/rescheduling of appointments. A missed clinic appointment or appointment for a scheduled procedure without calling to reschedule will be considered a “no show” for the appointment. “No shows” will be charged $25.00 for missed clinic appointments, or $100 for a missed scheduled procedure. Patients who consistently fail to show up for their scheduled appointments without providing 24 hour advanced notice can be terminated from the practice.

3. Prescriptions will only be filled during office hours by appointment only. No prescriptions will be filled after hours, on weekends, or holidays.

4. State law requires compliance and close monitoring for narcotic medications. If you are prescribed such medications, you will be asked to sign a *Patient Responsibility Agreement for Controlled Substance Prescriptions*.

5. Payment is due at the time services are rendered to the patient. Failure to settle past due balances, pay at the time of service, etc., can result in a patient’s termination from the treatment program.

Noncompliance with these guidelines will result in discharge from treatment at Pinnacle Pain Medicine. Your signature below constitutes acknowledgement and acceptance of the terms of these guidelines.

_____

Patient Name Date

_____

Signature of Patient/Legally Responsible Person Signature of Witness

Pinnacle
Pain Medicine

Advanced Practice Nurse/Nurse Practitioner and Physician Assistant Consent

Pinnacle Pain Medicine would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners, and Physician Assistants to assist us in a team approach to deliver our high quality of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) and Physician Assistants (PA) are mid-level practitioners who have received advanced education and training in the provision of health care. Advanced Practice Nurses/Nurse Practitioners or Physician Assistants are not doctors. They can however, diagnose, treat, and monitor routine and complex pain disorders.

If you are seen by an APN/NP or PA, your doctor will review your care with the APN/NP or PA as part of the care plan.

I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a APN/NP or PA.

I hereby consent to the services of an Advanced Practice Nurse/Nurse Practitioner or Physician Assistant for my healthcare needs.

I understand that I can refuse to see the APN/NP or PA and request to see a Physician.

I understand that this may require my appointment to be rescheduled.

☐ ***Please check this box to acknowledge that you have read and accept the above.***

Signature Date

Pinnacle
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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

The purpose of this agreement is to give you information about the medications you will be taking for pain management, and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Controlled substances can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible, given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship as well as full agreement and understanding of the risks and benefits of using controlled substances to treat pain.

1) You should use one physician to prescribe and monitor all controlled substances.
2) You should use one pharmacy to obtain all controlled substances prescribed by your physician. Should you need to change your pharmacy, you will need to notify Pinnacle Pain Medicine.

Pharmacy:_____Phone Number:_____

3) You should inform your physician of all medications you are taking, including herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.
4) You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. You are to take medications exactly as prescribed.
5) Refills of controlled substance medications:
    a. Will be given during *regularly scheduled office visits*. Refills will not be made at night, on weekends, or during holidays. **Please come to each appointment with the actual prescription bottles of the medications you are currently taking, and we will then review your medications during each individual office visit.** The prescriptions prescribed during each office visit should last until your next appointment with our office. Please remind us which medications you request be refilled.
    b. Refills will not be made because you "run out early," "lose a prescription," and/or "spill or misplace medication." You are responsible for taking medication in the dose prescribed, for keeping track of the amount remaining, and keeping it secured from theft. An "emergency," such as on a Friday afternoon, because "I suddenly realized I will run out tomorrow" will not justify

a refill. You need to call at least 48 hours ahead if assistance is needed with a refill which must be obtained in person, or picked up by an approved family member.

6) You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. Stolen medications should be reported to the police and to your physician immediately. Lost or stolen prescriptions may only be refilled if a police report is available to validate the circumstances.
7) It is against the law to give or sell your medications to any other person.
8) The use of alcohol while taking controlled substances is not advised.
9) There are side effects with controlled substances which may include, but are not limited to: skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive and/or motor ability. Overuse of controlled substances can cause decreased respiration.
10) If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with controlled substances for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for treatment of pain with controlled substances, but starting or continuing a recovery program is required. If the responsible legal authorities have questions concerning treatment, as might occur (for example, if I obtained medications at several pharmacies), all confidentiality is waived and these authorities may be given full access to Pinnacle Pain Medicine records of controlled substances administration. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given to you.
11) You understand that your physician may contact any healthcare professional, pharmacy, legal authority, or regulatory agency to obtain or provide information about prescription usage, if the physician deems it necessary.
12) ***You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing***. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your controlled substances when applicable, or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. You accept responsibility for the cost of the urine test in the event your healthcare coverage will not cover the cost of this test.
13) You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your prescribed controlled substances when applicable, or complete termination of the doctor/patient relationship.

14) Any evidence of drug hoarding, acquisition of any controlled substances from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, any deviation from your treatment plan, or failure to follow this narcotic agreement, may result in termination of the doctor/patient relationship.
15) You can be referred out to an addiction specialist if your doctor deems it necessary.

I understand that if I violate any of the above conditions, my prescription for controlled substances may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the use of non-prescribed illicit drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.

I have read this agreement and the same has been explained to me by Pinnacle Pain Medicine staff. In addition, I fully understand that the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from Pinnacle Pain Medicine.

Patient Signature_____Date _____

Witness Signature _____

Pinnacle
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Financial Policy

Thank you for choosing Pinnacle Pain Medicine. Our goal is to provide you with the highest quality care possible. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Therefore, we take this opportunity to answer some of the most commonly asked questions. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Payment Methods

Payment is expected at the time services are rendered. We accept a variety of payment methods, including cash, check, money order, or credit card Visa, Mastercard, Discover and AMEX. Credit card payments are also accepted via telephone.

Insurance Information

We must emphasize that your health is our primary concern, regardless of your insurance. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have, prior to your appointment.

We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Most insurance companies do not cover 100% of the cost of services, and there is a portion that the patient is responsible for. There are several patient responsibility components that may apply to an insurance payment.

Co-pay – A set dollar amount per office visit that is the patient's responsibility.
Co-insurance – A percentage of the charge that is the patient's responsibility.
Deductible – A set annual amount that the patient is responsible for paying prior to his or her insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance

and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued Photo ID.

Insurance Changes
If there are any changes in your insurance, you are required to call our office and give the detailed changes of your insurance at least twenty-four (24) hours prior to your appointment.

If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance.

Managed Care: All managed care (i.e. HMO, PPO, POS)
Co-payment, co-insurance & deductible amounts are due at the time of check-in. If your insurance plan requires a referral authorization from a primary care physician you are responsible for obtaining prior approval from your PCP prior to treatment & will need to present this at your visit. If you request an office visit or procedure without a referral authorization, your insurance plan may deem this as non-covered treatment and you will be responsible for the charges.

Medicare
We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare's allowed amount. All co-payments or deductibles are due and payable at the time of service.

Secondary & Tertiary Plans
We will bill your secondary insurance as a courtesy. We do not bill tertiary insurance. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding.

Preauthorization
Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required

Non-covered Services
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Auto Injury Cases
This office does NOT bill auto insurance for auto accident cases. We do NOT accept liens or letters of protection (LOP's).

Worker's Compensation
If your injury is work-related, we will need the claim number, date of injury, employer, and worker's compensation carrier prior to your visit in order to bill the worker's compensation insurance company.

Cash Patients Cash patients are accepted on a case by case basis. All uninsured patients will be required to pay in full at time of treatment.

Surgery & Injection Fees
All co-pays, co-insurance, deductibles, and payments for non-covered surgical procedures are due prior to surgery. We will make every attempt to determine your coinsurance amount prior to your surgery. This will be based on your insurance benefits and an estimate of the services to be provided. We will provide you with that estimate & we will expect to collect that amount prior to the time of surgery. If any changes are made to the scope of services provided and the coinsurance amount has changed, we will either refund or bill you upon final resolution of your account. Fees are ultimately the responsibility of the patient, whether your insurance company pays or not, and are due within thirty days of your receipt of Pinnacle Pain Medicine statement.

Nonpayment
Please be aware that patient accounts over 180 days without satisfactory payment will be turned over to a collection agency and patients will face possible termination from the program.

Returned checks A $25.00 fee will be charged for any returned checks and we will report bad checks to the District Attorney's Office. We will be unable to accept your check for any services thereafter.

Missed appointments
A scheduled appointment is a commitment of time between you and our practice, a time we have reserved just for you. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 hours in advance to avoid a service charge and help us meet the needs of other patients. Patients who habitually fail

to keep scheduled appointments and do not give a 24 hour cancellation notice will face treatment termination.

Children of Divorced Parents
Responsibilities for payment of patients, who are minor children, whose parents are divorced, rest with the parent who seeks the treatment.

Medical Records
Please direct all medical record requests or questions to your physicians' business office.

Charges for Forms
A $30.00 fee will be charged for disability, life insurance, and other forms requested by a third party or patient.

Special Circumstances
We are aware that circumstances in our daily lives may vary. If you need to establish a payment plan or require additional assistance, please contact our Business Office prior to your scheduled appointment. Unless you have made prior arrangements for payment of your balance, our financial policy will stand.

Account Billing Questions & Refunds
Questions or concerns regarding your account or insurance claim should be directed to our business office staff. If your account has a credit balance, we will promptly release a refund check to you once your insurance carrier has processed all pending insurance claims remaining on your account. If you feel an error appears on the statement or if you have any questions or concerns please contact our billing office immediately at (972) 715-5000.

_____
Printed Name

_____
Signature Date

Pinnacle
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*** Refill requests cannot not be authorized on the day they are received. They will require your Physician's approval.***

Medications are refilled only Monday through Friday during office hours (8:30am–3:00pm). Medications will not be refilled on evenings or weekends!

If you need a refill and do not have an appointment scheduled, please call your pharmacy and have them fax us a request **at least 1 week prior to needing your medications**. The medical assistant needs time to check your chart to see when you are due and speak with the physician to get permission to authorize the refill.

If your medication is a **"C-2"** script (i.e. Oxycontin, Percocet, Morphine, etc.) it will **ONLY** be refilled at your regularly scheduled office visit, unless the physician has given you other instructions. **Your Pinnacle Pain Medicine doctor should be the only physician to prescribe and monitor all controlled substances.**

Do not call the office several times to check the status of your refill. If you feel the need to follow up with the office regarding a fax being received, please leave a voicemail. Leaving multiple voicemails will only delay us from processing your request. **All authorized refill requests will be faxed by 3:00pm on the business day they are due.**

NO prescription will be refilled early! If you feel you need to take more medication than directed, please call the office ahead of time and let the Medical Assistant know so that she can relay the information to the physician. **Under no circumstances should you take your medication other than how it was prescribed.**

Please realize that these medications may be narcotics and are sometimes stolen. Medication that is stolen will only be replaced if you provide us with a police report. We will then call the police to verify the validity of the report. Medication that is lost will generally not be replaced. **It is essential that you take complete responsibility for the safety of your medication! Do not carry your bottle of medications with you.** If your medications are stolen a second time, there will be no early refills done.

*****If you are having a procedure done, the physicians will not refill your medications at the surgery center. These must be done at your regular scheduled office visit or via fax request from your pharmacy.**

I have read and had the above information explained to me.

_____ _____

Patient Signature Date