OUR FAMILY DOCTORS
PRESCRIPTION MEDICATION POLICY

The practitioners and staff at Our Family Doctors value the relationship we have with our patients. We strive to do our best when it comes to making sure you receive proper treatment including your medications. It is important you are aware of our medication dispensing policies that will apply for *all* medication prescribed by our office.

- **Please bring all of your medications to each appointment**, especially if you are on multiple medications or have seen other doctors in the months or weeks prior to your last appointment with us. It is important for us to know all of the medicine you are taking at all times. Simply saying "it's the same as last time" is not enough since even the smallest change (as in dosage or frequency) is important for us to know.

- Understand that if you are receiving any medications from our office, **you will need to be seen by the physician or PA at least every 3-6 months.** Your visit frequency will depend on your diagnosis and is at the discretion of the physician. This is necessary for many reasons, but especially to assure the medication is working properly.

- For refills on r*outine* medications, call your pharmacy and notify them of your refill request. The pharmacy will contact our office for approval. Al**low 2 days (excluding weekends) for your refill to be processed! *Do not wait until your medication is out***! Also note that medication refills will be processed during regular office hours only.

- For refills on any controlled substance/narcotic, it is our policy to ***not approve early refills*** **on controlled medications unless expressed permission is given by the doctor.** *Never* take any medication more frequently than it was prescribed. In addition, any medicines lost through crime or theft will require a *detailed police report* in order for a new prescription to be written. *There will be no exceptions to these rules*. (Please see separate sheet on Controlled Substance Policy of Our Family Doctors for more detailed information.)

If you have any questions or need further clarification of this policy, please let us know.

By my signature below, I verify that I understand and agree to the above medication policy at Our Family Doctors.

Printed Patient Name:_____ DOB_____

_____ _____
Patient / Guardian Signature Date

◯ Copy given to patient/guardian

Rx policy 092807