Arthritis and Osteoporosis Associates
Medication Policy

It is important for your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescriptions, over-the-counter drugs and supplements, that you are taking.

CONTROLLED MEDICATIONS

We will not refill controlled medications in advance of their refill date, **REGARDLESS OF THE SITUATION**, nor will we mail these prescriptions. They must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make an appointment, we require a two-day notice for a medication refill.

Please be advised you will be required to give a urine specimen for drug testing. **Automatic discharge** from the practice will occur for any of the following: forgery or diversion of the prescription, failure to comply with the recommendation of the physician, and any drug seeking behavior including but not limited to using the medication more frequently than recommended, repeated calling after hours to obtain prescriptions, repeated visits to the ER for the pain, use of medication beyond the expected treatment period and failure to notify your physician that you are receiving narcotics from other physicians. You may be referred to a pain management specialist or asked to have an evaluation by a mental health professional to help manage your pain.

STAFF

We require our staff to address our patients with professionalism, and we ask our patients to do the same. **If at any time our staff feels that your tone or language is offensive or abusive**, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. We will document a record and depending on the severity of the situation, you may be discharged from the practice.

We are committed to providing the best possible treatment and ask for your cooperation in following these policies.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Signature:_____ (Please sign form in office)

Print Name:_____ Date:_____