# Tennessee Valley Bone and Joint

## MEDICATION POLICY

______________________________ ____/____/____
Patient's Name Date of Birth

***In an effort to assure all your medication needs are addressed please discuss medication refills or changes with your provider at time of appointment***

- **Medication verification:** Please bring all medications which you are currently taking to each visit. Your medications will be verified before refills can be issued.
- **Medication refills:** Medication should only be taken as prescribed. Early refills will not be authorized. Medications will only be refilled or changed at the time of your scheduled visit. Refill prescriptions will only be filled at the same pharmacy as filled previously.
- **Medication replacement:** Lost or stolen medications will not be replaced.

| Pharmacy | Street Name | Phone |
|---|---|---|
| Alternative Pharmacy *(24 hour)* | Street Name | Phone |

You will not request or accept controlled substance medication (pain medication) from any other physician, health care provider or individual while you are receiving such medication from Tennessee Valley Bone and Joint. **Non-compliance with the above condition may result in re-evaluation of your treatment plan and discontinuation of controlled medication and/or discharge from our practice.**

**AUTHORIZATION TO RETRIEVE RX HISTORY FROM OTHER HEALTHCARE PROVIDERS AND 3RD PARTY PHARMACIES:** I agree that TN Valley Bone and Joint may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

## FORM FEE POLICY

We reserve the right to charge a fee to complete forms such as disability, FMLA, life, or other insurance forms. There is a service charge of $15.00 minimum per form up to 2 pages and $5.00 per page thereafter. Fee must be paid prior to completion of forms. We have a 7–10 day turn-around time for all forms to be completed, once fee is paid. We will make EVERY effort to return these forms in a timely manner as you may request.

## PATIENT ACKNOWLEDGEMENT OF ALL POLICIES ABOVE

I have read and agree to the above policies.

Patient's Signature: ______________________________ Date: ________________