MEDICATION AGREEMENT & REFILL POLICY

As part of your treatment, our medical staff may prescribe medications for you. Medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need to ensure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement:

Please initial next to each statement below:

1.______ I agree to follow the dosing schedule prescribed to me by my physician

2.______ I will never share, sell, or exchange my medications with anyone for any reason

3.______ **I understand that I must allow 1 business day for a refill request to be processed. I will contact my pharmacy prior to contacting the physician's office. Refill requests must be made by 4:00 p.m. and no on-call physician will provide refills on my medications.**

4.______ I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Baylor Neurosurgery Associates will not replace lost or stolen medication or prescriptions.

5.______ I agree that if I receive a pain-related prescription from Baylor Neurosurgery Associates that I am not allowed to accept pain-related prescriptions from any other physician without my physician's consent. I understand that my physician does not prescribe pain medication after 90 days and that if I am still experiencing pain, I will need to be re-evaluated.

6.______ I agree to use only one pharmacy for my pain-related medications. In the event that I must use another pharmacy, I will notify Baylor Neurosurgery Associates of this immediately and provide them with the new pharmacy's contact information.

7.______ **I agree to keep all scheduled appointment. I understand that no medications will be given for cancelled or no show appointments**. I understand that if I am late to my appointment that my appointment might have to be rescheduled.

8.______I know that I can not be seen at the office without a scheduled appointment for any reason.

9.______I understand that abusive behavior or harassment against Baylor Neurosurgery Associates staff will not be tolerated. The physicians will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.

By signing this agreement, you affirm that you have read the above agreement and that you understand and accept these terms. Non-compliance with this agreement may be terms for dismissal from the practice.

________________________________ ________________
Patient Name (please print) Date

________________________________ ________________________________
Patient Signature Witness