1ST CHOICE HEALTHCARE
Revolving around you

Medication Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. **If our medical staff at 1st Choice Healthcare, Inc. has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.**

GENERAL:

1. Medication refills will only be available during regular office hours, Monday through Friday from 8:00 am – 5:00 pm. A 48 hour notice is required for all prescription refills so please be courteous and do not wait until you are out of medication to call.
2. 1ST CHOICE HEALTHCARE, INC. may not prescribe controlled or habit forming medications on my first visit.
3. I agree to follow the dosing schedule prescribed to me by my doctor or APN.
4. I agree to **NEVER** share my medications with others, nor will I sell or exchange my medications for any reason.
5. I agree to always keep my medications safeguarded and within my control.
6. I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. 1st Choice Healthcare, Inc. will have no obligations to replace LOST OR STOLEN prescriptions or medications.
7. I agree to bring all of my prescribed medications from any doctor's office to 1st Choice Healthcare, Inc. for my office appointments.
8. I understand that abusive behavior or harassment toward any 1st Choice Healthcare, Inc.'s staff will not be tolerated.
9. I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from 1st Choice Healthcare, Inc..
10. I understand that 1st Choice Healthcare, Inc.'s physicians and providers have the right to refill or NOT TO REFILL medications prescribed to me by another physician or provider.
11. I understand when I call for a medication refill I will be prepared to give the medication name and strength, such as, milligrams, and the pharmacy phone number.
12. I agree to notify 1st Choice Healthcare, Inc. if I experience any adverse effects or dosage problems with my prescribed medications.

CONTROLLED OR HABIT FORMING MEDICATIONS:

1. **One Provider:** If I receive controlled or habit forming medication prescriptions from 1st Choice Healthcare, Inc., I am not allowed to receive the same type of medications from another physician without express consent or consultation with 1st Choice Healthcare, Inc..
2. **One Pharmacy:** I agree to use only one pharmacy for my controlled or habit forming medication prescriptions.
3. I understand there will be NO early refills of any narcotic or controlled medications prescriptions.

4. I agree to keep all scheduled appointments. I understand that no medications will be given for cancelled or no-show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I may have to reschedule.
5. I understand medication refills cannot be made after hours, on the weekends or on holidays.
6. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
7. I understand that harassment or abusive behavior toward any 1st Choice Healthcare, Inc. staff member will not be tolerated.
8. I understand that 1st Choice Healthcare, Inc. reserves the right to **REQUEST A URINE DRUG SCREEN AT ANY TIME WHEN I AM PRESCRIBED CONTROLLED SUBSTANCES.** If my screen tests positive for un-prescribed substances or negative for medication that I have been prescribed, I understand that this is grounds for dismissal from 1st Choice Healthcare, Inc..
9. Should I demonstrate questionable behavior or lack of improvement the 1st Choice Healthcare, Inc. provider may want to refer me for evaluation and/or treatment. I will willingly accept and attend any referral the provider makes on my behalf.
10. I understand that 1st Choice Healthcare, Inc.'s physicians and providers have the right to refill or NOT TO REFILL medications prescribed to me by another physician or provider.
11. I understand long term pain management (chronic pain for more than 6 months) may require a referral to a pain management specialist. Patients who are ***not willing*** to see pain management will be offered non- narcotic pain medication - such as cymbalta, lyrica, neurontin, etc. *Patients who are being treated for cancer related pain are **not** required to see pain management. Patients who are being treated by a specialist such as rheumatology or neurology for chronic medical problems such as rheumatoid arthritis, multiple sclerosis, or other serious diseases are **not** required to see pain management if their specialist agrees - in writing- with the long-term use of controlled pain medications.*
12. I understand controlled or habit forming medications may not have refills. Patients who require monthly prescriptions for these medications may be required to have monthly office visits to evaluate and document their pain and pain control.
13. I understand patients may be prescribed pain medication short-term for acute painful injuries such as sprained ankles or lacerations. These medications are for temporary use only and **will not** be refilled.
14. I understand patients who receive controlled or habit forming medications must sign an informed consent stating they are aware of the addictive nature of these medications.
15. I understand patients who are currently receiving controlled or habit forming medications and who are **not willing** to comply with this policy will be weaned off the medications.

Examples of Controlled or Habit Forming Medications (this is not a complete listing):

For Anxiety: Valium (Diazepam), Xanax (Alprazolam)

For Pain: Hydrocodone, Oxycodone, Morphine, Tramadol, Soma

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By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and that I have read, understood, and accepted these terms. I understand that I may be dismissed from 1st Choice Healthcare, Inc. if I do not abide by the terms of this medication agreement.

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION: I hereby authorize the Providers of 1st Choice Healthcare, Inc. to access historical prescription drug information.

No medications will be prescribed without the acceptance of this agreement.

_____ _____

Patient/Guardian Signature **Date**

_____

Printed Patient Name

_____

Pharmacy Name & Phone Number