



Prescription Refill Policy

In order to provide outstanding quality care Spine Physicians Institute, P.A. adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our physician, this allows you to update the physician on any changes in your medication or advise him of any new or ongoing symptoms.

We understand, however, that sometimes this is not possible and in those situations it will be necessary to follow our refill policy.

Please call your pharmacy for all prescription refills. Most pharmacies will contact our physician office regarding renewal of medications. Should your pharmacy decline renewal; your pharmacist will instruct you regarding the next steps to take.

When it is necessary to call in for a refill, please call the Medical Assistant of your physician.

In order to effectively process your prescription refill request, we will need the following information:

- Spell your first and last name
- Your date of birth
- Spell the name of the medication(s) to be refilled
- The name and location of your pharmacy
- Area code and telephone number where we can reach you

The following guidelines will be followed when processing your refill request:

- There will be no refills given on Fridays, weekends, or Holidays.
- A process time of **3 days** minimum will be needed for all requests.
- There will be no early refills, patient must follow prescription directions.
- Prescription phone-in/pick-up must be done Mon-Thu during business hours **ONLY** (9am-4:30pm).
- Non-controlled/non-narcotic prescriptions will require a follow up appointment every **3 months**.
- Controlled-substances/narcotic prescriptions will require a follow up appointment every **30 days**.
- New symptoms and/or events require a clinic appointment.
- No refills will be given for prescriptions not initiated by Spine Physicians Institute physicians.
- Signed "Prescription Refill Policy" required if using narcotic/controlled medications.

Anyone authorized to pick up your prescription must be listed here:

By signing below I agree that I understand and accept the policy listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____