Towne Lake
PRIMARY CARE
Family Medicine

900 Towne Lake Pkwy
Suite 410
Woodstock, GA 30189
(678) 445-0819

PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

I agree to allow **48 hours** for prescription refills.

I understand that prescription refill requests **after 2 pm** will not be received until the next business day.

I understand that a follow-up visit may be required from my Physician in order to obtain a refill.

I agree to take all medications exactly as instructed. I am **NOT** allowed to change dosage amounts, or alter the time schedule of taking the medication without permission from my Physician.

I understand that narcotics and non-narcotic medications will **NOT** be phone in after hours or on the weekend.

I understand that patients may be terminated from the practice, with a 30 day notice, for noncompliance in the taking of their medications, as deemed necessary for their continued care and well being of the patient.

I understand that Towne Lake Primary Care will **not** refill prescriptions that have been lost or misplaced.

I understand that I must keep all appointments as recommended. Failure to do so could result in discharge from the practice for noncompliance.

I agree that I will never give, trade, nor sell medications.

I understand that altering or forging of a prescription is a felony. Forging of prescriptions or any documents relating to our office would require immediate termination from the Practice.

I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive a vehicle, you could be charged with a **DUI**.

I agree that I will not combine any narcotic medications with the consumption of alcohol.

ONLY ONE PHARMACY MAY BE USED FOR FILLING PRESCRIPTIONS.

Pharmacy Name: _____ Pharmacy Phone # _____

I HAVE READ, UNDERSTAND, AND AGREE TO THE POLICIES ABOVE. I UNDERSTAND THAT IF I DO NOT SIGN THIS DOCUMENT, MY PHYSICIAN MAY REFUSE TO PRESCRIBE MEDICATIONS.

PATIENT NAME _____ DOB _____
Please Print

PATIENT SIGNATURE _____ DATE _____

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