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 $20.00. Fee must be paid prior to completion of forms. We have a up to 10 days for 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/Guarantor Signature: ____________________________ Date: _______________

Tennessee Valley Bone and Joint
2350 N. Ocoee St • Cleveland, TN 37311
(423)476-5554

The purpose of this agreement is to give you information about the medications and treatment you may receive for pain and to assure that you and your physician/healthcare provider comply with all state and federal regulations concerning the prescribing of controlled substances.
I agree that my orthopedic care may include opioids (morphine-like drugs) as part of my treatment for pain. I understand that these drugs can be very useful, but have a high potential for misuse and addiction and are therefore closely controlled by the local, state, and federal government**.**

If my physician/health care provider prescribes such medication to help manage my pain, I agree to the following conditions:

I am responsible for my pain medications. I agree to take the medication only as prescribed. I understand that increasing my dose without the close supervision of my physician/health care provider could lead to drug overdose causing severe sedation and respiratory depression and death.

I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at Tennessee Valley Bone and Joint.

There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing). It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion).

I am also responsible for notifying my practitioner immediately if I need to visit another physician/health care provider or need to visit an emergency room due to pain.

I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law**. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe.

If I have a history of alcohol or drug misuse/addiction, I must notify the physician/health care provider of such history since the treatment with opioids for pain **may** increase the possibility of relapse. Alcohol use is contraindicated. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity**.

I agree and understand that my physician/health care provider reserves the right to perform random or unannounced drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the provider/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy.

I understand that I am required to bring my pill bottle with me to every appointment before any additional prescriptions will be written.

Patient/Guarantor Signature: ____ DOB: ______________

TVBJ Witness Signature: ____ Date______________