Stephen M. Howell, M.D.

PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills
2. I understand that prescription refills requested after 4:00pm will not be received until the next business day
3. I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
4. Narcotics and non-narcotic medications will NOT be phoned in after hours or on the weekends.
5. Our physicians will NOT refill prescriptions that have been lost or misplaced.
6. I must keep all appointments recommended.
7. 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.
8. Only one pharmacy may be used for prescriptions.

Pharmacy Name: ________________________________

Pharmacy Address: ____

City: ______________________ State: ________ Zip Code: ______________

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 me pain medications.**

Patient Name: ____
(Please Print)

Patient Signature: _________________________________ **Date:** ______/_______/20______