Alfred J. Cook, Jr., M.D
Board Certified Orthopedic Surgeon
Specializing in Sports Medicine, Shoulder
Surgery, and Cartilage Regeneration

John T. Williams, Jr., M.D.
Board Certified Orthopedic Surgeon
Specializing in Total Joint Replacement

Megan Benoit, FNP-C, APRN, RNFA

Heather Fleming, FNP-C, APRN, RNFA

PRESCRIPTION POLICY

This agreement between the Patient: ___________________________________ and Prescribing Advanced Orthopedics Institute Provider is for the purposes of establishing agreement on clear conditions for prescription and use of pain control medications prescribed by the Provider for this Patient. Provider and Patient agree that this document is essential in maintaining the trust and confidence necessary in a Provider-Patient relationship.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Provider to the Patient.

I understand that the reduction in the intensity of my pain and the improvement in my quality of life are the goals for this medication.

I realize that all the medications have potential side effects and I will have any recommended laboratory studies required to keep the regimen as safe as possible.

I will not use any illegal controlled substances and I will not share, sell or trade any medication for money, goods or services. I will safeguard my medications from loss or theft and agree that the consequences of failure to do so is that I will be without my prescribed medication for some time.

I will not fill the prescription for pain medications from any other healthcare provider without telling them I am taking pain medication by the Provider. If another provider prescribes the pain medications for me, I will inform the Provider, in order to avoid duplication.

I agree that I will use my medication at a rate no greater than the prescribed rate, and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to call and request a refill within 2 days of my medication running out.

Acknowledgment of Driving Impairment: I acknowledge that while I am under the care of my Provider, I may be prescribed medication that could impair my ability to operate a motor vehicle, machinery, or other equipment. I realize that it is my responsibility to keep myself and others safe from harm, including the safety of my driving. If there is a question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform such activity until my ability to perform said activity has been formally evaluated, or I have not used any medication for at least four days. As such, I will refrain from operating a motor vehicle under the influence of prescribed medication that impairs judgment. I will arrange for proper transportation and use the proper precautions when taking prescribed medications.

Provider and patient agree that this agreement is essential to the provider's ability to treat the patient's pain effectively and failure of the patient to abide by the terms of this agreement may result in the withdrawal of the prescribed medication.

Patient's Signature:______________________________ Date:____________ Witness: _____________________________