

**Dr. John David Blankenship, D.O.**  
**Family Practice**

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Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

(Preferred to be called: \_\_\_\_\_)

Sex \_\_\_\_\_ DOB: \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Race: Caucasian \_\_\_ African-American \_\_\_ American-Indian \_\_\_ Asian \_\_\_ Hispanic \_\_\_ Other \_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

eMail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status: Never Married: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_

Name of your Spouse: \_\_\_\_\_

Spouses Employer: \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

What is their relationship to you? \_\_\_\_\_

What is their phone number? \_\_\_\_\_

Insurance Information: *(Please provide us with your new insurance card(s) for your chart)*

Primary: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary: \_\_\_\_\_ Policy #: \_\_\_\_\_

Who is financially responsible for your visits with us:    Self    Spouse    Parent

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**Privacy Rights**  
**HIPAA**

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

This is a summary of our Notice of Privacy Practices or Privacy Rights, which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices, or Privacy Rights. We may change the terms of our notice at any time and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has acted in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information.

You have the right to amend your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have a right to obtain a copy of this notice from us.

You may complain to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact. No retaliation will occur if a complaint is filed.

**Dr. John David Blankenship, D.O.  
Family Practice**

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**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notification of Privacy Rights**

I, \_\_\_\_\_ acknowledge that I have been advised of my privacy rights and the notice of Privacy Practices has been made available to me.

\_\_\_\_\_  
**Signature of Patient or Representative**                      **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Printed Name of Patient or Representative**

**Permission to Discuss My Medical Concerns**

Dr. John David Blankenship, D.O., LLC, or his affiliates can discuss my medical information or needs with the following individuals:

Name	Relationship	Phone Number
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Name	Relationship	Phone Number
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Signature of Patient or Representative	Date
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\_\_\_\_\_  
**Printed Name of Patient or Representative**

By checking this box you give Blankenship Family Medicine and its affiliates permission to leave voice mail messages on any phone number listed within your New Patient Packet Paperwork regarding appointments and medication refills.

By leaving the box unchecked, we will only leave a message requesting that you return our call, and no other information will be provided.

**Authorization to Release Protected Health Information**

Date: \_\_\_\_\_

Doctor's Fax #: \_\_\_\_\_

<b>PATIENT</b> _____	<b>DOB</b> _____
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**RELEASE INFORMATION FROM:**

\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**RELEASE INFORMATION TO:**

**Dr. John David Blankenship, D.O.**  
**204 Lowe Ave SE, Bldg 1, Suite 2,**  
**Huntsville, AL 35801**  
**Fax: 1-877-845-9969 /**  
**256-534-7268**

<b>INFORMATION TO BE RELEASED:</b>				
History & Physical	EKG's	Lab Reports	Hospital Notes	Any & All
Immunization Records	Pathology Reports	Radiology Reports	Hospital D/C Summary	
Clinic Notes	Operative Reports	Radiology Images	Billing Information	

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: \_\_\_\_\_

**ATTENTION:** This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

Legal Guardian or Conservator                       Health Care Agent (Health Care Power of Attorney)

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under the state or federal law. Please indicate your relationship:

Parent                       Legal Guardian

Signature (Required)	Date Signed (Required)
_____	_____
Printed Name of Person Signing	
_____	
Mailing Address	
_____	

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**Payment Policy**

Dear Patient:

Payment for services must be made at the time of your visit. Our office is an accredited user of the Visa, MasterCard, Discover, American Express and Health Care Programs. We also accept cash and checks.

**Self-Pay** patients will be charged \$150.00 per visit, plus any fees relating to additional in-office testing that may be required.

Patients with a **high deductible insurance plan** will be charged at the end of their visit for services rendered. Services generally range from \$100.00 - \$150.00, depending on the services needed.

I, \_\_\_\_\_ have read Dr. Blankenship's payment policy and understand that payment is expected at the time of my visit.

\_\_\_\_\_  
Signature of Patient or Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient or Representative

**Dr. John David Blankenship, D.O.  
Family Practice**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATION ALLERGIES**

MEDICATION	REACTION
No Medication Allergies: <input type="checkbox"/>	

FOOD/ENVIRONMENTAL (i.e., bee sting)	REACTION
No Food/Environmental Allergies: <input type="checkbox"/>	

**MEDICATIONS**

*(If additional space is needed, please write on the back)  
(If you have a list of medications, please give that to the nurse)*

<u>PRESCRIPTION MEDICATION</u>	<u>TIMES PER DAY</u>	<u>DOSAGE AMOUNT</u>		<u>Over The Counter Medications (Only the name is needed)</u>
I do not take any medications: <input type="checkbox"/>				

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**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FAMILY HISTORY** (Please circle)

(All immediate family members) Total Number of Biological Siblings: \_\_\_\_\_

*(If additional space is needed, please write on the back)*

<b>CONDITION</b>	<b>FATHER</b>	<b>MOTHER</b>	<b>SISTER</b>	<b>SISTER</b>	<b>BROTHER</b>	<b>BROTHER</b>
Alcohol Addiction	Yes No	Yes No	N/A Yes No	N/A Yes No	N/A Yes No	N/A Yes No
Alive or Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased
Anxiety	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Asthma	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Cancer (list type)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Clotting Disorder	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Depression	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Drug Addiction	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Heart Disease	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
High Blood Pressure	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
High Cholesterol	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Stroke	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Are you adopted?	Yes No					

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**LIFESTYLE PREVENTATIVE HEALTH**

QUESTION	ANSWER
How many hours of sleep do you get on average per night?	
How often do you exercise per week?	
What is the duration of time?	
What type of exercise?	
What is your diet? (i.e.; Regular, Plant Based, KETO, Mediterranean, or Other)	
What do you do for your Mental Health, Stress and Anxiety Prevention? (i.e.; Exercise, Yoga, Counseling, Meditation, Prayer, or Other)	
How much water do you drink a day?	

**SOCIAL HISTORY**

(Please put an answer in each field even if the answer is "0", "No" or "None")

Marital Status	Number of Children	Pets	Religious Preference
Are You A Current Smoker?	Number of Packs Per Day?	Are You A Previous Smoker?	When Did You Start and When Did You Quit Smoking?
Do You Use Other Tobacco Products?	What Kind of Tobacco?	Amount Per Day?	Do You Drink Alcohol?
How Often and How Much Alcohol?	What type of Alcohol do you drink?	Do You Use Recreational Drugs?	What Type of Recreational Drugs Do You Use?



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<b>TESTING</b>		
TEST	YEAR	N/A
AAA Screen		
Bone Density		
Cancer		
Cholesterol Panel		
Colonoscopy		
Glucose		
Heart Cath		
Lung CT		
Men: PSA		
Stress Test		
Upper Endoscopy		
Women: Pap Smear		
Women: Mammogram		

<b>IMMUNIZATIONS</b>		
VACCINE	YEAR	UNKNOWN or N/A
Flu		
Hepatitis B		
Pneumonia		
Tetanus		
Tetanus/Whooping Cough		
Shingles		

<b>BIRTHS</b>						
Pregnancies	Term	Preterm	Miscarriage	Termination Abortion	Living	Menopause Onset

<b>SURGERIES</b> <i>(Please check all that apply)</i>			
ABG	Aortic Aneurysm	Appendectomy	Breast Augment
Breast Reduction	C-Section	Carotid Endarterectomy	Cataract Extract
Colectomy	Ectopic Pregnancy	ESWL	Full Hysterectomy
Gallbladder	Gastric Banding	Heart Valve	Hernia
Hip Right Left BIL	Hip Fracture Right Left BIL	Intestinal By-Pass	Knee Arthroscopy – Right Left BIL
Knee Replacement - Right Left BIL	Knee Surgery – Right Left BIL	Lasik	LS Spine Surgery
Mastectomy	Oophorectomy	Pacemaker	Partial Hysterectomy
Prostatectomy	PTCA	Shoulder Right Left BIL	Sinusectomy (Nasal)
Splenectomy	Thyroidectomy	Tonsilectomy	Tubal Ligation
Vasectomy			
<b>No Surgeries:</b> <input type="checkbox"/>			

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**MEDICAL HISTORY**

*(Please check all that apply)*

Anemia	Anxiety	Arthritis	Asthma	Back Problem	BPH
Breast Cancer	CAD	Cancer*	CHF	COPD	Diabetes
Dementia	Depression	Dermatitis	Epilepsy	GERD	Glaucoma
Gout	Headache	Heart Attack	Hepatitis	High Cholesterol	HIV
Hypertension	Hypothyroid	IBS	Migraine	Nasal Allergies	Pneumonia
Renal Stone	Stroke	Ulcer (GI)			

**\*If you have cancer, please list the type of cancer you have:** \_\_\_\_\_

**REVIEW OF SYSTEMS** *(Please check all that apply)*

GENERAL	CARDIOVASCULAR	GENITOURINARY	SKIN
Fatigue/Daytime Sleepiness YES NO	Chest Pain YES NO	Frequent Urination YES NO	Rash YES NO
Weight Loss/Gain YES NO	Palpitations YES NO	Discomfort/Pain/Burning with urination YES NO	Change in Skin Lesion YES NO
Fever, Night Sweats YES NO	Shortness of Breath with Exertion YES NO	Women: Hot Flashes, Irregular Periods YES NO	New Skin Lesion YES NO
		Men: Decreased Urine Stream, Dribbling Urine, Multiple Need to Urinate at Night YES NO	
EYE	RESPIRATORY	NEUROLOGIC	HEAD, EARS, NOSE, THROAT
Eye Pain Yes No	Wheezing Yes No	Dizzy Spells Yes No	Hearing Problems Yes No
Vision Change Yes No	Cough Yes No	Speech Problems Yes No	Sore Throat Yes No
	Excessive Snoring Yes No	Memory Problems Yes No	Runny Nose Yes No
		Headaches Yes No	
ENDOCRINE	GASTROINTESTINAL	MUSCULOSKELETAL	PSYCHIATRIC
Excessive Thirst Yes No	Heartburn Yes No	Joint or Bone Pain Yes No	Sad Yes No
Swelling in Neck Yes No	Abdominal Pain Yes No	Back Pain Yes No	Irritable Yes No
Easy Bleeding or Bruising Yes No	Blood in Stool Yes No	Neck Pain Yes No	Suicidal Yes No
Other			

204 Lowe Ave SE, Bldg 1, Suite 2, Huntsville, AL 35801

Office: 256-534-7235 / Fax: 256-534-7268

### Practice Information for Patients

Welcome to the Family Practice of Dr. John David Blankenship, D.O. We are truly honored and grateful that you have chosen to trust us with your medical care. Blankenship Family Medicine was established to provide individualized care for families.

Dr. Blankenship was raised in Huntsville, however he has lived in various locations since leaving for college in Nashville in 1988. He graduated from Kirksville College of Osteopathic Medicine in 1997 and finished his Family Practice Residency in Montgomery, AL in 2001. After eight years in a family practice group in Corbin, Kentucky, he moved his family back to Huntsville in 2009. He spent three years working in emergency medicine and urgent care clinics in North Alabama. His experiences motivated him to open a family practice that combines the best of modern technology with a comprehensive, individualized approach to care in July 2012. This will hopefully produce high quality integrative healthcare with measurable results and improved patient satisfaction. To accomplish this goal, the practice will focus on the principles of access, interaction, reliability and viability. Ultimately, most of our decisions are made in order to allow Dr. Blankenship to spend a few more minutes with each patient.

In order to provide this type of healthcare, it is essential that the practice maintains a low overhead, a manageable volume of patients, leverages technology and empowers patients to participate in all aspects of their healthcare.

#### **APPOINTMENTS:**

\_\_\_\_\_ It is important that you bring all your medicine bottles with you to each visit. All refills of daily medications  
Initial should be handled at your visit. **Please make your appointments 2 weeks prior to running out of your medicines.**

\_\_\_\_\_ To remain a patient at BFM, you must have a yearly physical at our office.  
Initial

\_\_\_\_\_ Payment – Your co-pay or self-pay payments are expected at the time of your service. For patients  
Initial without insurance, you are a “Self-Pay” patient and your fee is \$150.00 for each visit, plus additional charges for any in-house testing.

\_\_\_\_\_ For sickness or urgent complaints – We will try to see patients within 24 hours.  
Initial

\_\_\_\_\_ Telemedicine will be performed when necessary, and standard co-payments will be required.  
Initial

\_\_\_\_\_ Routine Visits for Chronic Problems – Are scheduled in a 3-month window.  
Initial

\_\_\_\_\_ Cancelation/No Show – Please provide at least a 24-hour notice if you need to cancel your appointment.  
Initial Failure to do so will result in a \$75.00 “No Show” charge. We do have an answering service that you can leave a message with. If you fail to show for your scheduled appointment you will incur a “No Show” fee of \$75.00.

\_\_\_\_\_ Please be on time - When an appointment is made for you, that slot is reserved for your health care. Being  
Initial on time is crucial for the courtesy of our other patients and for the staff. If you are 15 minutes late for your scheduled appointment, we will ask that you reschedule, and you will incur a \$75.00 charge for a missed visit.

\_\_\_\_\_ Please silence your cell phones – If you need to make or receive a call, please step outside for the courtesy  
Initial of our other patients. Please do not hold conversations in the lobby, triage room or exam rooms on your speaker function.

**OFFICE HOURS:**

Initial

Monday – 8:00 – 5:00  
Tuesday – 8:00 – 12:00  
Wednesday – 8:00 – 5:00  
Thursday – 8:00 – 5:00  
Friday – 8:00 – 5:00

\_\_\_\_\_ We are closed for lunch daily between 12:00 and 1:00, (our phones are forwarded to our answering service  
Initial 30 minutes before lunch and 30 minutes before closing time).

**MEDICINE POLICY:**

Initial

If possible, generic medicines will be prescribed. Medications that require prior authorization or higher co-pays will be avoided unless they are deemed necessary for your well-being.

If a medication needs to be changed for any reason, (i.e., a cost increase, insurance change, pharmacy transfer, etc.), an appointment will be required.

Your medication refills should be requested at your office visit. You will need to schedule an appointment to receive a refill(s) on your medication. Please do not wait until you are out of medication to contact us. The nurse has 48 hours to respond.

Dr. Blankenship will not call in antibiotics, pain/sleep medications or refills of routine medications after our normal daily business hours.

**FORMS:**

Initial

Please bring all forms that need to be completed by Dr. Blankenship at the time of your appointment. A \$50.00 charge will be incurred for lengthy and detailed forms. A \$50.00 charge will be applied for any forms that need to be completed outside of an office visit. This includes, but is not limited to, short term disability, life insurance, insurance applications, sports physical, college physical, FMLA, subpoena for lawsuits, free medicine applications, auto insurance, etc. Adoption/Foster Care forms are subject to higher fees. Please contact the office.

**PATIENT PORTAL:**

Initial

Take control of your health information with our Patient Portal. The Patient Portal allows us to communicate more effectively with our patients. To set up your Patient Portal, we will provide you with a temporary username and password. Please go to [YourHealthFile.com](http://YourHealthFile.com) to begin setting up your Patient Portal. With accessing your Patient Portal you will have access to your important medical information such as, your lab results, test results, pre-clinic labs, and when your appointments are. New Patients will be sent a Registration link to set up your Patient Portal. Patients without a computer or internet access will be provided the necessary paperwork to be completed.

**SOCIAL MEDIA:**

Initial

Please follow us and like us on Facebook: John David Blankenship, D.O.

Our website is always open! Please visit our website for current information and important notifications:  
[www.blankenshipfamilymedicine.com](http://www.blankenshipfamilymedicine.com)

**Dr. John David Blankenship, D.O.  
Blankenship Family Medicine  
204 Lowe Ave SE, Bldg 1, Suite 2, Huntsville, AL 35801**

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**Patient Right & Responsibilities**

You and your family are our number one concern during your visit to Blankenship Family Medicine. The following statement of your rights and responsibilities is presented as the policy of this facility but does not presume to be a complete representation of all-mutual rights and responsibilities.

**YOU HAVE THE RIGHT TO:**

Initial

- Receive considerate, respectful care, which always recognizes your personal dignity, under all circumstances.
- Participate in decisions involving your care. Except in an emergency situation, you shall not be subjected to any procedure without your voluntary, competent and understanding consent or the consent of your legally authorized representative.
- Refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.
- Information about Advance Directives, such as Living Will or Durable Power of Attorney for Health Care, that would allow you to make your own health care decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
- Instructional and educational information about your medical treatment in a language and terms that you understand.
- The confidential treatment of and personal access to your medical record.
- Know who is responsible for providing your direct care and to receive information concerning your continuing health care needs and alternative for meeting those needs.
- Have access to interpreter services, free of charge to the patient.

**YOU HAVE THE RESPONSIBILITY TO:**

Initial

- Give Dr. Blankenship and the staff of Blankenship Family Medicine complete and accurate information about your condition and care.
- Follow the instructions of Dr. Blankenship and the staff of Blankenship Family Medicine, and to keep appointments relative to your care.
- Make it known whether you clearly understand planned actions and treatment and what is expected of you.
- Accept responsibility of his/her actions should he/her refuse treatment or not follow Dr. Blankenship's orders.
- Report unexpected changes in your condition to Dr. Blankenship and the staff of Blankenship Family Medicine.
- Accept the financial obligations associated with your care.
- Be considerate of other patients in the waiting area. Be considerate of Dr. Blankenship and his staff.
- Follow the policies and procedures of our Practice Information for Patients.
- Bring a current copy of any Advance Directives to be placed in your medical chart.
- Notify Blankenship Family Medicine of a request for interpreter services.
- Arrive for your scheduled appointment on time. Call reminders are a courtesy and are completed by a third party. We have no control over their system and if they experience any down time or service interruptions.

**Blankenship Family Medicine**  
**J.D. Blankenship, D.O.**  
**Frequently Asked Questions / Problems with Prescriptions**

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**Due to the high increase of requested pharmacy assistance phone calls, there will be a**  
**\$20.00 service charge (payable in advance)**  
**for us to contact your pharmacy regarding a pharmacy issue to resolve the problem.**

Initial

Most prescription issues need to be handled by your pharmacy. The best course of action is to review the common issues below and to contact your pharmacy directly to discuss how to resolve your pharmacy issue.

**Issue: My prescriptions are not at my pharmacy:**

**Possible Solutions:**

- Please call your pharmacy and ask them if they have your prescription(s).
- Did you change your preferred pharmacy recently? If so, have you advised our staff?
- Did you miss or reschedule your last appointment? If so, please make an appointment.
- Are you getting this medication from Dr. Blankenship, or possibly another doctor?

**Issue: My prescriptions are not at my mail order pharmacy:**

**Possible Solutions:**

- Please call your mail order pharmacy and ask them if they have your prescription(s).
- After you have called your mail order pharmacy, call us and we will resend your prescriptions electronically.

**Issue: My pharmacy says I am out of refills:**

**Possible Solutions:**

- Ask your pharmacy if there is a new script that is currently on hold. With each prescription comes a certain prescription number and a certain number of refills. When the refills run out, a new prescription replaces it with a new prescription number. For example, If you have one refill left on prescription 123456, when that last refill is filled, the pharmacy will have a new script "on hold" for you. When the new script is filled it will have a new prescription number, even though it is the same medication.
- If the pharmacy says they do not have any refills on hold, call us.

**Issue: My pharmacy says my script is on hold:**

**Possible Solutions:**

- Simply ask to speak with the pharmacist and request that they fill it. The pharmacy puts prescriptions on hold until your current prescription runs out of refills.
- Your current prescription might not be out of refills yet. The pharmacy will not fill another prescription for the same medication until your current prescription refills run out.
- It might be an insurance issue. If your last refill was only a partial refill, i.e., the script is for 90 days, you're expecting 90 pills, but they only gave you 30 pills; that might be your insurance. Some insurances will only allow a certain number of pills within a certain amount of time. Your pharmacy will be able to explain that to you and instruct you accordingly.

**Issue: I am out of refills:**

**Solution:**

- Call our office and make an appointment. We will only refill medication during an appointment. Please contact us at least 2 weeks before you run out of your medication.

**Issue: Controlled Substance Refill**

**Solution:**

- We do not call in, or electronically send in controlled substances outside an appointment. Controlled substances often require a paper prescription that you physically bring to your pharmacy. Patients taking controlled substances regularly are usually required to have an appointment every 3 months. Please contact us at least 2 weeks before you run out of your medication.

Initial