The Advanced Spine Center

160 E. Hanover Avenue, Suite 201
Morristown, NJ 07960

333 Mount Hope Avenue, Suite 140
Rockaway, NJ 07866

720 US 202/206 North, Bldg. 2
Bridgewater, NJ 08807

Mailing Address: P.O. Box 2266, Morristown, NJ 07962 Phone (973) 538-0900 Fax (973) 538-0909

Prescription Policy and Refill Request Procedures

Please call 3 business days before your medication is due to be refilled. This will allow us ample time to fulfill your request.

1. Please call the office at (973) 538-0900 between the hours of 9:00am and 4:00 pm Monday – Thursday and Fridays 9:00 – 12:00 Noon.
2. All refills called in after 2:00 pm **will not be** addressed until the next business day.
3. Please give all relevant information whether speaking to a person or leaving a message:
    A. First and last name and your date of birth
    B. Phone number where you can be reached
    C. Name of the medication and dosage information
    D. Pharmacy name and number

    Please be advised that you are to only use 1 pharmacy to fill your medications.
4. Any medications that need to be hand written may be picked up in the Sparta office on Tuesdays or the Cedar Knolls office on Fridays. **Prescriptions will NOT be mailed.**
5. All patients must have a follow-up appointment scheduled with the doctor within **90 days** when receiving Schedule II narcotics as mandated by New Jersey State Law. All others must have a follow up appointment scheduled as mandated by the doctor.
6. **You may NOT receive narcotics from multiple physicians.**
7. You must take the medication as prescribed by the doctor. You may **NOT** vary the dosage without authorization from the doctor.
8. **Any unauthorized alterations or modifications to a prescription are cause for immediate discharge from the practice.**

    Please note that you are responsible to make sure that you DO NOT run out of your medications on weekends or holidays.

I hereby understand and will comply with the above set refill request and prescription policy. Any violation of the above set rules will result in the immediate cessation of services provided to you by Advanced Spinal Care & Associates LLC ("The Advanced Spine Center".

Pharmacy Name: _____ Pharmacy #: _____

Sign: _____ Date: _____

Doctors Initials: _____