Metropolitan Behavioral Services
"Helping you to live in your reality"
4741 Atlantic Blvd. Ste. C Jacksonville, Florida 32207
Phone: 904-562-1391 Fax: 904-374-3057

MEDICATION REFILL REQUEST POLICY

Effective on this date, _____, I have read, understand and agree to adhere to the following policy regarding refills on medication from my doctor. **I will provide 7 (seven) days' notice to obtain a refill prior to completely running out of medication.** I understand that there are **NO EXCEPTIONS** to this policy!

DO NOT WAIT UNTIL THE LAST MINUTE TO REQUEST THE REFILL BECAUSE THE REQUEST MAY NOT BE ADDRESSED IN TIME OR YOU MAY NOT GET A FOLLOW UP APPOINTMENT BEFORE YOU RUN OUT OF MEDS!

I further understand that if my insurance company requires a prior authorization (letter, phone call or form completion) there may be an additional fee (minimum $25.00) applied to your account which insurance will not cover and must be paid PRIOR to the prior authorization being completed. The fee is to compensate your doctor for his time corresponding with the insurance company. The payment of the fee does not ensure the approval of the medication by your insurance company.

Patient Signature: _____ Date: _____