McKinley
Orthopedics, Sports Medicine & Spine

Prescription Refill Policy

In order to provide outstanding quality care McKinley Orthopedics adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our providers, this allows you to update the provider on any changes in your medication or advise them of any new or ongoing symptoms.

It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so please be courteous and plan ahead.

Medication refills will only be addressed during regular office hours Mon-Fri (9-5pm). The after hours 5-8pm urgent care service or answering machine will not return any phone calls regarding refills. Please contact the office on the next business day to place your refill request.

In order to effectively process your prescription refill request, we will need the following information:

- Date of Request
- First and Last Name
- Date of Birth
- Name of Medication and Dosage
- Date that the current prescription will run out
- Name of your pharmacy
- Contact number to reach you

The following guidelines will be followed when processing your refill request:

- There will be NO refills given on weekends, or Holidays.
- A process time of 3 days minimum will be needed for all requests.

There will be no early refills, patient must follow prescription directions

- Requested medications cannot be picked up at the office.
- Prescription medications that are lost or stolen will not be replaced.
- No refills will be processed for prescriptions not initiated by McKinley providers.
- Some medication refill requests will require a follow up appointment.
- New symptoms and/or events will require an office appointment.
- Signed “Prescription Refill Policy” is required for all medication prescriptions.

By signing below I understand, agree and accept the policy listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Signature: _____ Date: _____

Print Name: _____

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