



## PRESCRIPTION REFILL POLICY

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Dear Patient:

We strive to fulfill your prescription request(s) in a timely manner, as your health is very important to us. In order to do so, we are requesting that you please review the following:

1. We ask that you call in your prescription refill request(s) at least 3 days in advance. Please allow 1 to 2 business days for most refills. Bioidentical hormone and thyroid refills often take longer to process and may take up to 3 business days.
2. We require that you are seen in office at least once per year for an examination. Based on your diagnosis, you may be required to be seen more frequently (e.g., every 3 months, 6 months, etc.). Please schedule your appointment far enough in advance to avoid running out of your medication before your appointment. Your prescription may not be refilled if you have not been seen in office within a year of your request.
3. Hormone Prescription Refill Requests
  - a. **Female Patients on Bioidentical Hormone Replacement Therapy:**
    - Your annual exam may include a pap smear/pelvic exam and breast exam. At the time of your visit, the appropriate type of breast imaging will be discussed, such as thermography, mammogram, ultrasound, or breast MRI.
    - Routine pap smear/pelvic screenings may be done at our office or elsewhere. Please note you may still need an annual pelvic exam performed by a Born Clinic Provider to check for abnormalities, as this is necessary to prescribe bioidentical hormone replacement therapy.
    - If your breast exam and/or pap smear/pelvic exam are performed elsewhere, contact your provider and request a copy be sent to our office. Please do so before you call with a refill request.
      - *Please note: your prescription refill request(s) may be delayed if we do not have up-to-date copies in your file.*
  - b. **Male Patients on Bioidentical Hormone Replacement Therapy:**
    - You will be required to have bloodwork every 6 months, as well as an EKG with your annual visit.

We appreciate working with you to ensure high quality medical care.  
Thank you for choosing Born Clinic for your health care needs.



# WRITTEN ACKNOWLEDGEMENT FORM, RECEIPT OF PRESCRIPTION REFILL POLICY

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I have read and understand Born Clinic's *Prescription Refill Policy* and agree to its terms. I acknowledge that I have received a copy and understand that such terms may be amended by the practice at any time.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If signed by a personal representative:*

Name of Personal Representative: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

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