FREEMAN SPINE & ORTHOPEDIC MEDICINE

Patient's Name: _____ Chart Number: _____

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. opioids, narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by the local, state and federal government. They are intended to relieve pain, to improve function and / or ability to work, not simply to "feel good." Because my physician is prescribing such medication for me to help manage my condition, I agree to the following:

1) I AM RESPONSIBLE for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will NOT be replaced.

2) I will not request or accept controlled substance medication FROM ANY OTHER PHYSICIAN OR INDIVIDUAL while I am receiving such medication from FREEMAN SPINE & ORTHOPEDIC MEDICINE. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.

3) Controlled substance medications will be made ONLY DURING SCHEDULED APPOINTMENTS, in person, once each month (or as arranged by the practitioner).

a) Refills will NOT be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

b) Refills will NOT be made as an "emergency". I will call at least SEVENTY-TWO (72) BUSINESS HOURS ahead if I need assistance with a controlled substance medication prescription.

4) I will provide the name, location and telephone number of my pharmacy and I understand that I am only permitted to use THIS pharmacy. If at any time I use a different pharmacy to fill a prescription, I will notify the office immediately. Failure to comply will result in immediate discharge from the practice.

5) I will BRING IN THE CONTAINERS of all medications prescribed by this office each time I see the practitioner, even if there is no medication remaining. These will be in the original containers from the pharmacy for each medication. If enrolled into the Chronic Pain Program, or any other program, I agree to the necessary psychological evaluation and testing.

6) I understand that IF I VIOLATE any of the above conditions, my controlled substances prescription and / or treatment may be terminated. If the violation involves obtaining controlled substances from another individual, I may be reported to my physician, medical facilities, pharmacy and other authorities.

7) I understand that state law PROHIBITS DRIVING OR OPERATING DANGEROUS EQUIPMENT while taking any sedating medication, even if I do not feel sedated.

8) I have NO WISH to harm myself or others.

9) I AGREE, with full informed consent, to provide tissue, or body fluid for drug analysis when requested for routine screening.

10) I AGREE to allow FREEMAN SPINE & ORTHOPEDIC MEDICINE to discuss any and all aspects of my care with my treating practitioners, obtain records and pharmacy information when needed.

11) I understand that diversion, prescription alteration, and the use of illicit substances is a crime and may be considered a FELONY. I agree in protecting the community and that these acts may be reported and fully consent to such reports.

I have been fully informed regarding physical dependence and psychological dependence (addiction) of a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on some medications. Should this occur I will stop the medication only under medical supervision or I may have withdrawal symptoms.

I have read this agreement and it has been explained to me. In addition, I fully understand the consequences of violating this document and agree to the necessary actions for any such violations.

Patient's Signature: _____ Date: ___/___/___ Witness Signature: _____ Date: ___/___/___