NON-SURGICAL ORTHOPAEDICS, P.C.
Specializing in Spine Care & Pain Management

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Pain Management Agreement

Patient Agreement for Controlled Substance Prescriptions:

Controlled Substance medications (narcotics, tranquilizers, and barbiturates) can be an important part of the treatment of chronic pain when other options such as surgery, therapy, and injections have failed or are not warranted. In such cases, careful monitoring of the dosage and administration frequency is essential to control pain and avoid adverse effects. The patient understands there is a potential risk of addiction, abuse, misuse and mental impairment due to the medication(s). The patient further understands that the medication may cause drowsiness. and they should avoid driving or operating heavy machinery while on the medication.

If controlled substances are prescribed as part of the treatment plan, this agreement shall go into effect. Accordingly, I agree to comply with the following statements:

1. I am solely responsible for my specific controlled substance medication. If the prescription is lost, stolen or taken more frequently than prescribed, it will not be replaced without an examination by the physician. A follow up appointment will be made “as available” to assess the situation. Medications will NOT be refilled for “missed” appointments.
2. I have no prior history of or treatment for drug abuse, misuse, diversion, or addiction.
3. I will not accept or request or utilize any controlled (or illegal) substance medications from ANY other facility, physician or individual while I am receiving medications from Non-Surgical Orthopaedics, P.C., without the knowledge of and written approval of my physician.
4. Under no circumstances will I increase the dosage or frequency of medications without approval from my physician. This change will be documented in my medical record.
5. I understand that calls for refills or changes of medications will be accepted ONLY between the hours of 8:00 am to 3:00pm, Monday through Friday. Under NO circumstances will refills or changes be made after hours, on weekends, or on holidays.
6. In understand refills will not be made if I "run out early" or on an "emergency" basis. I am responsible for the proper dosage, administration, and monitoring of the amount of medication.
7. Should my physician feel that such is warranted, I agree to undergo random drug testing through the administration of a urine drug screen. I understand that I am responsible for the cost of this test.
8. Should my physician feel that circumstances warrant an investigation, I formally authorize Non-Surgical Orthopaedics, P.C. to communicate with any pharmacy or physician to determine whether a similar medication has been filled in my name, or for any other reason.
9. I understand there will be no change in medication or prescription unless the unused portion of the original prescription is accounted for at our facility.
10. I understand that I may be required to fill the prescription or medication at a pharmacy designated by the practice.
11. I understand and accept the inherent risks of addiction, substance abuse, and potential side effects or hazards associated with the use of narcotic medications or other controlled substances, and my physician has discussed them with me.

I understand that if I violate any of the conditions above, my participation in the Pain Management Program can be terminated immediately, and my action may be reported to the Drug Enforcement Agency, other physicians, and pharmacies.

Name:_____ Signature:_____

Witness:_____ Date:_____

Medications and Dosage: All Narcotics