SPORTS AND SPINE ORTHOPEDICS

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Medication Treatment Contract

The purpose of this agreement is to prevent any misunderstanding about the ordering and filling of certain medications that may be required for the management of pain. This contract will also help comply with the laws regarding pharmaceuticals. I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines.

I agree to use only one pharmacy to have prescriptions filled. I choose to use the following pharmacy for all my prescriptions:

Name of pharmacy: _____

Address: _____

Phone: _____

These are the terms of the medication contract:

1. If I change my pharmacy for any reason, I agree to notify my doctor with the new address and phone number prior to filling any prescriptions.
2. I will use one physician to provide medication for me. I understand that if I seek a prescription for narcotic medications from another provider or facility, this will break my contract and this office will no longer prescribe my medication.
3. I will safeguard medication from loss or theft. Lost or stolen medication will not be replaced.
4. I agree that refills for pain medication will be made only at office visits or refill requests placed with my pharmacy.
5. Refills will not be given during weekends or evenings.
6. This office will not provide early refills.
7. If a long-term medication regimen is needed to control your pain, we will help transition your care to your primary care physician for long-term medication management.
8. I agree that I will use my medicine at the prescribed rates and that use of my medicine at a greater rate will result in my being without medication for a period of time.
9. I will not sell, share or trade my medication. I will not use any illegal controlled substances.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescription of medications, and I authorize my doctor to provide this information to any person or facility he/she deems appropriate or necessary.

_____ _____

Patient Name Date Signed

_____

Patient Signature