Chronic Pain Medicine, Narcotic/Opioid & Controlled Substance Agreement

I, _____ _____, agree to the following expectations:
(Patient's Full Name)

1. I understand that I am being prescribed strong medicine(s) and I have been informed of the common side effects which I will promptly report to my prescribing physician.
2. I know I may become dependent or addicted to the medicine(s). I agree to take the medicine/s exactly as prescribed and to not suddenly stop, increase or decrease the medication without my physician's guidance due to possible life threatening withdrawal symptoms and/or overdose.
3. I must avoid driving or operating machinery as the medicine(s) may make me sleepy or dizzy.
4. I understand that the prescription will not be refilled early and I am responsible for properly taking and safeguarding the medicine(s). Any signs of misuse of the medication will be reason for the prescriber to discontinue prescribing to me.
5. I agree that the medicine(s) will be prescribed for no more than 28 days at a time by my physician or one covering for him/her and at the time of my clinic/office appointment.
6. I agree to show up for my appointments at the clinic/office regularly as advised.
7. The treatment will be stopped immediately If I am found not to take the prescribed medicine or take anything not prescribed by my physician, or if I attempt to fill my prescription at an Emergency Room or by another physician/provider.
8. No refills will be made on evenings, weekends and holidays or by phone or fax.
9. I will use only the following pharmacy to fill all my prescriptions:

   Pharmacy Name: _____ _____

   City:_____ Phone: (____)_____
10. I understand that lost, stolen or damaged medications will not be replaced.
11. I agree not to sell, lend, or share my medicine with any other person.
12. I agree to not drink alcohol or use any illegal drugs, marijuana or methamphetamine.
13. I agree to submit my urine and/or blood specimen for alcohol and drug tests at any time.

14. I agree to participate in tests, other treatments (exercise, physical therapy, behavioral therapy, rehabilitation and acupuncture etc.) or evaluation by other specialists recommended by my physician.

15. I am not pregnant at this time and will avoid becoming pregnant while taking this medication.

16. I agree that I am currently not using illegal drugs and have never been involved in sale, illegal possession, diversion or transport of a controlled substance.

17. If any of the above rules are broken, my medicine(s) may be stopped without advance notice.

Patient Name_____ Signature_____ Date_____201_

Witness Name_____ Signature_____ Date_____201_

Physician Name_____ _Signature_____ Date_____201_