

NARCOTICS AND OTHER CONTROLLED SUBSTANCES AGREEMENT

This agreement is entered into the ___ day of _____, 20__ between _____ (patient) and Oracle Pain Clinic, Inc.

After a review of your medical history including all interventions offered and after risk stratification, it may be determined that you require narcotic medications for your chronic pain condition. You have been told, and are fully informed, of the risks, complications, and side effects of the medications before proceeding with the medication therapy.

This contract applies to; treatments and all Medications: Narcotic and other controlled substance, prescribed at the Oracle Pain Clinic. By signing below you agree to the following terms.

Failure to comply with any of these terms may result in discontinuation of therapy and discharge from the Oracle Pain Clinic. This contract constitutes a legally binding contract, and each line must be initialed and signed below.

_____ Medications can be filled at only 1 the following: Pharmacy Name: _____ Address _____
City _____, Telephone _____. I agree to never use another pharmacy to obtain medications without informing the Oracle Pain Clinic.

_____ If I test positive for ANY Illegal drugs my Narcotic Medication can be stopped. I also attest to the fact that I will NOT sell, trade, or exchange my medication, and obtain or use any other persons. Narcotic Medications this behavior may lead to discharge from the practice or I being placed on probation.

_____ I have been told use of the narcotics with alcohol and other controlled substance can cause serious complications including death and I agree not to engage alcohol use with my medications or during my treatment..

_____ Lost or stolen prescriptions will not be replaced without a police report. This will only be allowed one time only and the quantity and duration that will be administered is at the discretion of the provider. Moreover, the provider at his sole discretion may refuse to refill the narcotic. I am responsible for the security of all prescription medications.

_____ I will notify my physician of ANY side effects immediately. If I experience any sedation symptom, I will notify my physician. I understand that my medications may impair my ability to drive or operate machinery. I agree not-to operate heavy machinery or operate motor vehicles in accordance with the laws of the State of Ohio.

_____ I agree and consent to random drug screening and pill counts at **ANY TIME** during my treatment with narcotics. I agree to pay **ALL COSTS** associated with the medications, the drug screens, physician office visits and any other costs. I agree to follow up as determined safe by my provider. I agree that my functional status and pain control will be assessed at frequent intervals and if it is determined that the medications are not working, they will be stopped.

----- I may be asked to see an addiction specialist or a clinical psychologist or a psychiatrist if my physician thinks is indicated and failure to comply with that will lead to discharge from the clinic.

----- You grant us permission to call the pharmacy to inquire about your medications from the pharmacist if the need arises, and you authorize and consent to inquiries from the pharmacist. Moreover, based on our provider's evaluation it may be imperative to discuss and/or involve a family member in your care for your own safety and you authorize and agree to such disclosure.

----- I certify that I have not provided any false information or misleading medical history or seeking treatment under false pretense.

The patient agrees to release and hold harmless Oracle Pain Clinic, its providers, employees and agents from all liabilities caused by or resulted from the patient's use or misuse of the prescribed medications

I have read the above conditions and terms and have had all of my questions regarding these conditions and terms explained to my satisfaction. I agree to honor all the conditions and terms. If I am unable to read or comprehend this agreement, I have requested assistance and this-agreement has been explained to me.

Witness _____

PATIENT _____

ORACLE PAIN CLINIC, INC.

By _____