Treatment Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medication for you. As you know, medications have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure that your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

I, ______________________________ understand that the possible complication of chronic opioid therapy may:

- Constipation, dry mouth, nausea, vomiting, or decreased appetite
- Dizziness, tiredness, or lightheadedness
- Respiratory depression
- Muscle twitches, sweating, itching
- Decreased urination
- Decreased sex drive
- Physical dependence
- Addiction
- Over dosage and death
- (Females Only) Chronic substance use may pose serious risks to fetus, therefore contact your provider immediately if you are or suspect that you may become pregnant

If you experience any of the following serious side effects, stop taking the narcotic and seek immediate emergency medical attention:

- An allergic reaction (difficulty breathing, closing of your throat, swelling of your lips, tongue, or face hives)
- Slow, weak breathing, or any breathing difficulties
- Seizures
- Cold, clammy skin
- Severe weakness or dizziness
- Unconsciousness

****Narcotics can cause physical dependence. Do not stop taking them suddenly. ****

Side effects other than those listed here may also occur. Consult the prescriber about any side effects that seem unusual or is especially bothersome.

1. I agree to follow the dosing schedule prescribed to me by my provider. Use of my medication at a greater rate may result in me being without medication for a good period of time and/or discharged from the practice.
2. I will **never** share, sell or exchange my medication with anyone, for any reason.
3. I understand that I am solely responsible for the safe keeping of my medications. I will treat my medications as I would any valuable possession. I know that it is at **Orthopaedic Specialists of North County's discretion to replace lost or stolen prescriptions or controlled medication and that such situation will subject my case to a thorough review in addition to urine screens and random pill counts.**
4. I understand that I should not drive or operate heavy machinery while I am taking medication that are causing drowsiness or impaired cognitive function.
5. I agree to notify Orthopaedic Specialists of North County if I experience any adverse effects or dosage problems with my prescribed medications.
6. I agree that if I receive a controlled substance prescription from Orthopaedic Specialists, I am not allowed to accept controlled substance prescriptions from any other physician without doctor's consent.
7. I understand that my provider follows regulations of the California Department of Justice (DOJ) and may routinely obtain Patient Activity Reports (CURES) from them, which provides a list of all controlled medications that are filled at pharmacies.
8. I understand my provider **can only give me post-op medications up to 90 days** & **cannot fill any narcotics after the post-op period** based on the new regulations.
9. I understand that if I run out of my narcotic medications due to overuse or loss of medications, I may not be able to obtain early refills. I understand that being without my narcotic medications can lead to withdrawal and other adverse side effects from not having my medications. **For refill requests of controlled and uncontrolled substances, please allow 72 hours for processing.**
10. I understand my provider can only prescribe the quantity allowed by the DOJ.
11. The prescribing physician or physician's assistant has my permission to discuss all diagnostic treatment details with my dispensing pharmacist or any other healthcare for the purpose of maintaining accountability.
12. I agree to use only one pharmacy for my pain related medications. In the event, that circumstance requires the use of another pharmacy; I will notify Orthopaedic Specialists immediately and provide them with all pertinent contact information. The pharmacy I have selected is:

Local Pharmacy Name: ______________________________ **Phone**: __________________

Address: ____

13. I understand that my medication refills will not be honored after regular business hours, weekends or holidays.
14. I understand that medication may not be given for cancelled or no-show appointments.
15. I understand that I must have an appointment in the office for medication to be dispensed.
16. **I understand that abusive behavior or harassment toward any Orthopaedic Specialist Staff will not be tolerated. The doctors will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.**
17. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from Orthopaedic Specialist of North County.
18. I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my provider to submit a copy of this agreement upon request. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.
19. I agree to disclose to Orthopeadic Specialist of North County if I am currently or become under the care of a pain management provider and/or have a pain medication contract with another provider.
20. **I attest that I am not at risk to myself or others.**

By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and that I have read, understood and accepted these terms. Non-compliance with this agreement can be terms for dismissal from the practice.

Patient's Signature ____

Patient's Name (Printed) ____

Date__________________