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Treatment Agreement & Refill Policy
Orthopaedic Specialists of North County

1. Medication Risks

I understand opioid medications may cause side effects including constipation, nausea, dizziness, respiratory depression, decreased sex drive, physical dependence, addiction, overdose, or death. I will seek immediate medical attention for serious reactions such as allergic reactions, difficulty breathing, seizures, or loss of consciousness. I understand narcotics can cause physical dependence and should not be stopped abruptly.

2. Medication Use & Safety

- I will take medication **only as prescribed.**
- I will **not share, sell, or misuse** my medication.
- I am responsible for keeping my medication secure. Lost or stolen prescriptions may not be replaced and may require review, urine drug screening, or pill counts.
- I will not drive or operate machinery if medication causes impairment.
- I will inform my provider of side effects or medications prescribed by other providers.

3. Controlled Substance Policy

- My provider will review the California **CURES database** when prescribing controlled substances.
- Post-operative narcotics may only be prescribed **up to 90 days,** as allowed by law.
- Early refills will **not** be provided, including for lost, stolen, or overused medication.
- Please allow **72 hours for all medication refill requests.**

4. Pharmacy Policy

- I will use **one pharmacy** for my pain medications.
- I authorize communication between my provider and pharmacist regarding my prescriptions.

5. Conduct Expectations

- Harassment or abusive behavior toward staff will not be tolerated and may result in dismissal from the practice.
- Forged, altered, or fraudulent prescriptions will result in **immediate termination of care.**

6. Additional Agreements

- I will notify Orthopaedic Specialists of North County if I am under a **pain management contract** with another provider.
- I agree to cooperate with pharmacy, state, or law enforcement investigations related to controlled substances.
- I attest that I am **not a danger to myself or others.**

Patient Acknowledgment

I have read and understand this agreement and agree to follow these policies. Failure to comply may result in discontinuation of medication or dismissal from the practice.

Pharmacy Name: _____ Phone Number: _____

Patient Signature: _____

Printed Name: _____

Date: _____ BC22