Carolina SPINE & NEUROSURGERY Center
7 Vanderbilt Park Dr. ● Asheville, N.C. 28803 ● (828) 255-7776

Name___________________________________

Account__________________

Provider__________________

Medication Treatment Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines you could be taking for pain management. This is to help both you and your doctor to comply with the state and federal law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

Females Only: If you plan to become pregnant or believe that you have become pregnant while taking this pain medication, your obstetrician must be notified immediately and this office must be informed.

I understand that if I violate this Agreement, my doctor may stop prescribing these pain-control medicines, discharge me from the practice, and may also inform my referring doctor, medical facilities, and other authorities.

In this case, my doctor will taper off the medicine over a period of several days, as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. A history of alcohol or drug abuse increases the risk of addiction.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines ***from any other health care provider***.

I will safeguard my pain medicine from loss or theft. **Lost or stolen medicines will not be replaced**.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings, weekends, or holidays. Prescription requests or renewals require a 24-hour notice.

I agree to use only one pharmacy. If for some reason I need to change pharmacies or use more than one, I will contact the physician and pharmacy about the change.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. I understand that I will not be able to obtain an early refill on my medication.

I will not consume alcoholic beverages while on this medication. Consumption of alcoholic beverages may result in rapid release and absorption of a potentially fatal dose of medication.

I will bring all unused pain medicine to every office visit.

I understand that if I require chronic pain medication, I will be referred to a pain specialist for medical management of my pain. I understand that Carolina Spine & Neurosurgery Center does not provide pain medication for chronic pain management.

I understand that my doctor has an obligation to report any condition that can impair the ability to drive (such as taking the medication) to the N.C. Department of Transportation.

I understand that a photo ID and signature are required to pick up medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Contract to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree to follow these guidelines. A copy of this document will be provided to me at my request.

Patient Signature: ____ Date: ____________________

Witnessed by: ____