OPIOID AGREEMENT

This is an agreement between_____ (the patient) and Dr. Duncan, concerning the use of opioid analgesics (narcotic pain-killers).

- I understand that the medication will probably not completely eliminate my pain, but is prescribed in order that I may become more functional and improve my quality of life. I agree to try NON-NARCOTIC MEDICATIONS and participate in modalities such as PHYISCAL THERAPY and INJECTIONS in order to reduce or eliminate the need for narcotics.
- I understand that opioid analgesics are strong medications for pain and that there are potential risks and side effects including physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms. Although not life-threatening, these symptoms can be quite uncomfortable. Overdose on this medication may cause death by stopping my breathing. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive or operate machinery that could put my life or someone else's life in jeopardy.
- I understand that if I am pregnant or become pregnant while taking opioids, my child would be physically dependent and withdrawal can be life threatening for a baby.
- I agree to take this mediation ONLY AS PRESCRIBED and not change the amount or frequency without discussing it with Dr. Duncan. RUNNING OUT EARLY, needing EARLY REFILLS, and ESCALATING DOSES without permission may be signs of misuse and may result in discontinuation of the medication. I agree to keep my medication in a safe and secure place. LOST, STOLEN, or DAMAGED medication will not be replaced.
- I agree that the opioids will be prescribed by only ONE DOCTOR and will be filled by only ONE PHARMACY (see below). I agree not to take any pain medication prescribed by any other physician without first discussing it with Dr. Duncan. I give permission to verify compliance through other facilities and the North Carolina Controlled Substance Reporting System.
- I agree not to share, sell, or in any way give my medication to any other person. I understand that this type of behavior is illegal and, if suspected, Dr. Duncan may notify LAW ENFORCEMENT. I may be required to come into the office for a RANDOM PILL COUNT within two hours of notification.
- I understand that if I am VERBALLY OR PHYISCLLY ABUSIVE to any staff member or engage in any illegal activity such as altering a prescription, this will be grounds for discharge form the practice.
- I agree not to consume ALCOHOL, ILLEGAL DRUGS or OTHER MOOD-ALTERING SUBSTANCES while I am receiving opioids prescribed at Atlantic Spine and Pain. I agree to submit to a URINE DRUG SCREEN at any time to verify compliance.
- I agree to attend ALL required follow-up visits and understand that failure to do so will result in discontinuation of this treatment. I agree to bring ALL PRESCRIBED MEDICATION IN THEIR ORIGINAL BOTTLES TO EVERY OFFICE VISIT. Refills for controlled substances or changes of my prescriptions will only occur at SCHEDULED APPOINTMENTS. If I cancel or miss my appointment, I may not receive my prescription and risk having withdrawal symptoms.
- I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

Patient Signature_____ Doctor Signature _____

Pharmacy_____ Location_____ Date_____