

NARCOTIC AGREEMENT

This is an agreement between _____, SS# _____, (me, the patient) and the Redpoint Medical, PSC (RM, my providers). It explains how I receive my medications (pain medication, narcotics, muscle relaxers, sedatives, sleeping medications or other controlled drugs prescribed by RM). It lists my responsibilities. I agree to take my medication responsibly and to follow all orders.

1. I agree to use the following pharmacy only: _____, in _____ (city) at _____ (telephone).
2. I will attend all of my office visits. I will come in immediately if asked.
3. I will not go to the ER or to other providers for these or similar medications.
4. I will bring my medication bottles to my appointment if instructed to do so.
5. I am personally responsible for my medications. I will treat them as my other valuables. I understand that they will not be replaced if lost, stolen, or destroyed.
6. I will not give my medication(s) to anyone else or take anyone else's medication(s).
7. I will not request early refills or take more than the prescribed amount.
8. For safety reasons, refill requests will only be honored at the time of my appointments, during office hours, currently 8AM-5PM Mon-Fri.
9. I will inform my doctor of any new medications or medical conditions.
10. I agree to allow RM to perform any urine, blood, or breath tests needed to make sure I use my medications correctly.
11. I will not operate a car or other equipment when I use my medications unless expressly approved to do so by RM.
12. It is my responsibility to comply with applicable laws while taking these medications.
13. I will not use alcohol or illegal drugs when using these medications.
14. My providers may discuss my medications with other appropriate individuals or entities to insure safety.
15. I understand that there can be side effects from these medicines, including sedation, itching, nausea, vomiting, difficulty urinating, constipation, and other problems.
16. I understand that I may become addicted to these medications.
17. I understand that suddenly stopping these medications may be dangerous.
18. If I violate these conditions, my providers may not refill the medications and may require that I obtain help to decrease my use of these medications.
19. I know that violating these conditions may result in my dismissal from the practice with no more than 30 days notice.
20. I further agree that my pain medication or other prescriptions may be stopped or decreased at any time, for any reason, by my providers.

Finally, I understand that the above is not a complete list. I will be careful and will exercise caution and common sense. I will be completely honest, open, and accurate about my use of these and all other medications. I will ask questions if I do not understand something or if I feel that I may be having trouble with the medication.

Patient Name _____

Witness Name _____

Patient Signature _____

Witness Signature _____

Date _____