Ohio Pain Clinic, LLC

MEDICATION CONTRACT: After a through review of your medical history, failure of conservative, medical, and surgical management, it may be determined that you require narcotic medications for your chronic pain condition. You have been told of the risks, complications, and side effects of the medications, prior to proceeding with the therapy. This contract applies to all Medications: Narcotic and Non – Narcotics, prescribed at the Ohio Pain Clinic. By signing below you agree to the following terms. Failure to comply with any of theses terms may result in discontinuation of therapy and termination treatment at the Ohio Pain Clinic. This is a legally binding contract, and must be initialed and signed below.

_____ Medications can be filled at only 1 pharmacy. This pharmacy is _____ telephone number is _____. I agree to never go to another pharmacy to obtain medications without calling the Ohio Pain Clinic. No other person is allowed to take medications prescribed to me.

_____ I will only obtain narcotics from one physician. I will not ask **ANY** physician to fill my narcotic medications without consent from the Ohio Pain Clinic. I will not go to any Urgent Care, Emergency Room, or **ANY** Medical Practitioner and obtain Narcotics without informing the Ohio Pain Clinic within 1 business day. I will notify the Ohio Pain Clinic immediately if I obtain narcotics from any another provider. The provider at the Ohio Pain Clinic is the only one who may refill my narcotics.

_____ Lost or stolen prescriptions will not be replaced without a police report. This will only be allowed once. The medications will also **NOT** be replaced if lost or stolen for **ANY** reason unless a police report is obtained.

_____ I will take my medication as directed. I will not deviate from my treatment plan. My medications **will NOT be refilled early**. **I WILL NOT CALL THE PHYSICIAN OFFICE AFTER BUSINESS HOURS** to get a medication refilled. If I call for a refill after business hours, I realize that my request will not be answered. **I WILL NOT** request refills for Narcotics over the phone. I realize that an office visit is required to request a medication refill.

_____ I will notify my physician of ANY side effects immediately. If I experience any sedation symptoms I will notify my physician. I am not recommended to operate heavy machinery or operate motor vehicles, unless I am on these medications chronically without signs of impairment. I understand that my medications may impair my ability to drive or operate machinery

_____ I agree and consent to random drug screening at **ANY TIME** during my treatment with narcotics. I agree to pay **ALL COSTS** associated with the medications, the drug screens, physician office visits, and **ANY COSTS** associated with the Narcotic Treatment Program. I agree to follow up in 1-month intervals for medication refills. I agree that my functional status will be assessed at frequent intervals and if it is determined that the medications are not working, they will be stopped.

_____ If I test positive for ANY Illegal drugs my Narcotic Medication can be stopped. I also attest to the fact that I will NOT sell, trade, or exchange my medication, and obtain or use any other persons Narcotic Medications

_____ I agree that my medication can be stopped at **ANY** time at the consent of the Physician.

_____ I will not use any illegal drugs nor will I mix alcohol with my medications.

PATIENT:_____ PHYSICIAN: _____