Spine & Orthopedic Center of N.J., LLC.

90 Sparta Avenue ▪ Sparta, NJ 07871 ▪ (973) 726-9500 ▪ Fax (973) 726-8218

PAIN MANAGEMENT CONTRACT

The purpose of this contract is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and the Clinicians at Spine & Orthopedic Center of N.J., LLC to comply with the law regarding controlled pharmaceuticals.

Please initial each statement of the contract.

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

_____ I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines.

_____ 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 would also be agreeable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.

_____ 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, nor will I misuse or self-prescribe/medicate with legal controlled substances.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opiod pain medications, controlled stimulants, or anti-anxiety medications from any other doctor.

_____ I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced. If stolen, any consideration by the Physician can only be made with the presentation of a police report explaining the incident.

_____ I agree that refills of my prescriptions for pain medications will be made either at the time of an office visit or via the dedicated prescription line. Instructions for the prescription line are attached. Failure to use this dedicated line will result in not having your medication renewed. Refill requests should not be made on evenings, weekends, or holidays. Refills requests, left with the answering service will not be honored.

_____ I understand that any changes in medication will require an office visit with a Clinician of Spine & Orthopedic Center of New Jersey, LLC.

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I agree to use: _____
Pharmacy Name and Location

Phone Number _____

_____ I authorize the doctor and my pharmacy to cooperate fully with 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 medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, primary care physician and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a urine analysis to determine my compliance with my program of pain control medications.

_____ 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 agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____day of _____, 2013.

_____
Patient Name Printed

_____
Patient signature

_____
Witnessed by