Boston Spine & Scoliosis

Reducing the trauma of Spine Surgery ®

Minimally Invasive Surgery of Cervical, Thoracic, and Lumbar Spine, Board Certified

Pain Medication Agreement

The purpose of this agreement is to prevent misunderstanding about certain medications you may be taking for pain management. This is to help both you, and your doctor, comply with the law regarding controlled pharmaceuticals.

- I understand this agreement is essential to the trust and confidence necessary in the doctor-patient relationship and that my doctor will render treatment based on this agreement.
- I understand my doctor will only prescribe narcotic pain medication post-operatively. The length of time that these medication(s) will be prescribed post-operatively varies depending on the surgical procedure performed; however, medication(s) will not be managed for post-surgical pain for greater than three (3) months. At that time, my doctor will refer me to a pain clinic for long term pain medication management.
- I will communicate fully with my doctor about the efficacy of the medication(s) prescribed.
- I will not use any illegal controlled substances, including cocaine, unprescribed narcotics, etc.
- I agree that I will use my medication at a rate no greater than prescribed. The use of my medication at an unauthorized rate will result in my being without medication.
- I will not share, sell, or trade my medication(s) with anyone.
- I will safeguard my medication(s) from loss of theft. I understand that lost or stolen medication(s) will not be replaced. **Early refills will not be permitted under any circumstances.**
- I understand that if I break this agreement, my doctor will no longer prescribe medication(s) to me.
- I authorize my doctor to provide a copy of this agreement to my pharmacy.
- I agree that I will submit a blood or urine test if requested by my doctor to determine compliance with my prescribed pain medication(s).
- I will keep track of my medication(s) and request refills in a timely manner. I will notify staff of a prescription refill request by calling the office at least two (2) days prior to running out. **Refills will not be made during evenings, weekends, or holidays.**
- I agree to only obtain pain medication(s) from one (1) provider. Should I receive a prescription from another provider, I will notify the office immediately to avoid my medication(s) being discontinued.
- If my preferred pharmacy is out of stock of medication(s) I am prescribed, I understand it is my responsibility to find a pharmacy that does have the medication(s) available and notify the office to send the medication(s) to the new pharmacy.

I, _____, have read and understand the above policy and agree to comply with this policy. I understand that failure to follow this policy will result in discontinuation of the prescribed medication(s). The pharmacy I prefer to use for filling prescriptions for all pain medication(s) is:

Name _____

Address _____

Patient Signature _____ Date Received _____

Provider Signature _____ Date Received _____