Premiere Health and Wellness
912.809.2341

Narcotic Agreement and Refill Policy

Pain management is an individualized process. A plan that works for one person can be different for that of another. As part of your treatment, our physicians may prescribe narcotic medications for you. Many of these medications may have serious side effects if not taken properly. It is your responsibility to understand the prescribed medication regimen, take medicines only as directed and communicate their effectiveness to our provider. Your health and safety are important to us, and we need your help in following our guidelines. If we have any questions or concerns regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies. Please review and sign below:

- I agree to follow the dosing schedule prescribed to me by my doctor.
- I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.
- I agree to notify us if I experience any adverse effects or dosage problems with my prescribed medications.
- I agree that if I receive any narcotic prescriptions from prescriber, I am not allowed to receive the same type of medications or other narcotics from another physician without consent from prescriber. This includes ER visits. Before accepting any narcotic medicine from any other physician, I will ask that physician to contact prescriber for approval.
- I agree to be evaluated at regular intervals for continuous narcotic treatment as advised by the medical staff or prescriber.
- I agree to use only one pharmacy, which is _____, for my pain related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify prescriber of all information pertaining to additional pharmacies, mail-order or other sources.
- I agree to bring all medications I am currently taking to each appointment and/or procedure with prescriber. This includes all prescription medications, vitamins and herbal supplements.

- I will actively participate in Return to Work (RTW) efforts and in any program designed to improve function including social, physical, psychological, and daily or work activities.

- I understand that I should not drive or operate heavy machinery while I am taking medications that may affect my cognitive function and/or cause drowsiness.

- I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Under NO circumstances will prescriber replace lost or stolen prescriptions or medications.

- In the event that my physician feels that my dose of pain medication is excessive or makes the diagnosis of addiction, he/she will reduce the medicine over a period of time as necessary to avoid withdrawal symptoms. A drug-dependence treatment or detoxification program may be recommended.

- I understand that abusive behavior or harassment toward any provider staff will not be tolerated.

- I understand that dealing with a forged or falsified prescription will result in immediate dismissal from prescriber.

- Prescription Pickups – On rare occasions a controlled prescription may be requested and approved for office pickup without a scheduled appointment. Once the refill has been approved by the provider **only the patient** may pick up the prescription. The patient must show a photo ID. Pain medication prescription will not be mailed.

- I understand that prescriber will require me to submit to a urine drug screen at random intervals. If my screen tests positive for unprescribed substances, illicit drugs or negative for medications that I have been prescribed, I understand that this is possible grounds for dismissal from the practice. If the physician feels a repeat drug screen is indicated, I understand that I may be responsible for the payment of this test if denied for payment by my insurance company.

By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood and accepted these terms. NO pain medications will be prescribed without the acceptance of this agreement.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____