NEUROSURGICAL CONSULTANTS, INC.

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SPINAL INSTRUMENTATION

Pain Management Agreement

The purpose of this Agreement is to clarify expectations and prevent misunderstandings about certain medicines you will be (or are) taking for pain control. This Agreement will help both you and your practitioner to comply with the law and policies regarding controlled pharmaceuticals. This Agreement also clarifies expectations of you, your practitioner, covering practitioners, nursing staff, local pharmacies, and others.

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

I will communicate fully with my practitioner, other practitioners, and nursing staff 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.

I may use alcohol responsibly. If I use alcohol to excess, my practitioner may terminate this Agreement because of the risks of mixing controlled pain medications and alcohol and the difficulties to evaluate the effectiveness of such medications in people who abuse alcohol.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including narcotic pain medicines, controlled stimulants, or anti-anxiety medicines from any practitioner, medical practice, ER, or hospital other than from my primary practitioner. Such controlled medications include, but are not limited to Tylenol #3, Percocet, Vicodin, Fioricet, MS Contin, OxyContin, Duragesic, Methadone, Xanax, Ativan, Klonopin, Valium. Ritalin, and Adderall.

I will safeguard my pain medicine and prescriptions from loss, theft, or destruction. Lost, stolen, or destroyed medicines or prescriptions will **not** be replaced. I will take this responsibility seriously because of the adverse effect on my degree of pain control if I am without medication. If my pain medication or prescription is stolen, I will report such incident promptly to the police and fully cooperate with such authorities.

I will safeguard my pain medication from children and others in my home and related locations to prevent unintentional ingestion of these medications by others.

If I need to seek medical care from another practitioner, medical practice, ER, or hospital, such as for emergent care of specialty care, I agree to inform them of all medications that are prescribed for me and that I cannot accept or use controlled substances if prescribed by any one except my primary practitioner.

I agree that refills of my prescriptions for pain medicine will be provided only at the time of an office visit or during regular office hours. All refills will be authorized and provided by my primary practitioner. If my primary practitioner is unavailable on the day or during the period that my medication is due to be refilled, a covering practitioner will issue such prescription, either for the usual/full amount of pain medication or for a sufficient supply until my primary practitioner is available. No refills will be available during evenings, on weekends, or on holidays. I will be responsible for noting when I will probably run out of medication and need a refill; I will plan accordingly. I will provide my practitioner or office staff with at east one business day's notice before a refill is due.

I agree to use a single pharmacy for all of my prescriptions related to this Agreement:

Pharmacy _____

Phone _____

Location _____

If I need to change pharmacies on a permanent basis, I will notify my practitioner in person or in writing, in advance, so that this Agreement may be amended.

I understand and expect that all practitioners and nursing staff and my pharmacy will cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my practitioner and to provide a copy of this Agreement to my pharmacy and to my insurance company or other regulatory body as requested (for example, Medicaid for prior authorization or approval of certain pain medications). 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 blood or urine test if requested by a MHS practitioner to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at the rate and manner prescribed. I understand that use of my medicine at a greater rate than prescribed or in a manner not prescribed will result in (1) my being without medication for a period of time or (2) termination of this Agreement as noted below. If I feel that my pain is not well controlled and that I need more pills or a different dose, I will contact my primary practitioner to discuss these concerns.

Prescriptions for pain medications will generally **not** be refilled early. If a prescription is scheduled to be refilled on a holiday or if I am going to be out of the area for several days when my prescription is scheduled to be refilled, my practitioner may, authorize an early refill. If my practitioner does this, he or she will note that my next refill will be due later. In no case will a prescription be refilled early by more than seven (7) days. Prescriptions will not be refilled early on a regular basis. I clearly understand the implications of this paragraph and will plan accordingly for any trips out of the area, such as to visit family.

If requested by a practitioner or staff member, I will bring all unused pain medicine to my next office visit.

I understand that my practitioner may not be able to prescribe medications that entirely relieve my pain. I understand that my practitioner may need assistance from specialists or other health care providers to fully evaluate and treat my pain (such as anesthesia providers, pain management clinics, psychiatry, neurology, physical therapy), and I agree to comply with his/her recommendations for such evaluations or joint care. I understand that my failure to comply with these components of the pain control treatment plan may lead to termination of this Agreement as described below.

I agree to treat all practitioners and staff in a respectful and professional manner at all times. I will not use foul or profane language, threaten or abuse any practitioner or staff member. I will not be disruptive to practitioners, staff, or other patients.

I understand that, if I violate or break any condition in this Agreement, even once, my practitioner may terminate this Agreement and stop prescribing these pain-control medicines. In such case, no other practitioner will prescribe such medications, either. In this case, if medically appropriate, my practitioner will taper off the medicine over a period of days to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended for me. Moreover, depending on the individual conditions of my violation(s) of this Agreement and the status of my patient/practitioner relationship, my practitioner may permanently dismiss me as a patient from the practice with thirty (30) days written notice.

I voluntarily 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 this _____day of _____ in the year_____.

Parties to the Agreement: Signatures:

_____ _____
Patient Name (Print) Patient Signature

_____ _____
Practitioner Name (Print) Practitioner Signature

_____ _____
Witness Name Witness Signature