NARCOTIC PRESCRIPTION AGREEMENT

Controlled substance medications (narcotics) can be very useful, but have a high potential for misuse and abuse, and are therefore closely controlled by the local, state and federal governments.

Used properly they are very effective pain medication. If used excessively, however, they can cause adverse effects such as vomiting, constipations, lethargy, or even death. To insure that these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled medications. **IF THE PRESCRIPTION OR MEDICATION IS LOST, MISPLACED OR STOLEN, OR IF USED IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.**
2. **I will not request nor accept controlled substance medications from any other physician or individual while I am receiving such medication from my Dr.** _____ (Except if I am a patient in a hospital). Besides being illegal to do so, it may endanger my health.
3. **REFILLS** or controlled substance medication **will be made only during regular office hours** 8:00AM through 5:00PM Monday through Friday, or in person during a scheduled office visit. Refills will not be made at night, on holidays or weekends.
4. I understand **if I violate any of the above conditions or decline to take a urine test for controlled drugs at my physician's request**, my controlled substance prescriptions and/or **my treatment at G & K Medical Associates P. C. may be duly terminated.** If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my primary physician, local medical facilities and other authorities.

I have been informed by my physician, about narcotic effects, including normal physiologic effects or **tolerance** (need for more medicine to achieve the same pain relief), **dependence** (withdrawal will occur if I stop the medication abruptly), and **addiction** (abnormal psychological dependence), which is uncommon in patients in pain.

I understand that the MAIN TREATMENT GOAL is to improve my ability to function and /or work. In consideration of that goal, I agree to help myself by following better health habits. Especially exercise, proper nutrition, and limiting the use of unhealthy substance. I understand that only through a healthier lifestyle can I hope to have that most successful outcome of my treatment.

_____ _____

Patient signature Witness

_____ _____

Printed name Date