Pain Care & Natural Medicine Center of Charleston
Marc Dubick, DDS, MD
2097 Henry Tecklenburg Drive, Suite 203 West
Charleston, SC 29414
Tel: 843-573-3444 Fax: 843-769-4312

CONTRACT FOR OPIOID (NARCOTIC) PRESECRIPTION & MANAGEMENT
Patient Consent & Use

This contract is made by and between Pain Care & Natural Medicine Center of Charleston (Pain Care), its physicians and non-physician practitioners, and the patient whose signature appears below, and is for the purpose of clarifying conditions for the prescription / use of pain-controlling medications. Because opioid (narcotic) drugs are controlled substances, the patient herein acknowledges the necessity for maintaining trust and confidentiality in the doctor / patient relationship, of which this contract is a part.

I, (Patient) _____, agree to and accept the following conditions for the management of pain through the use of prescribed opioids:

Opioid medications may be prescribed by: _____, of Pain Care. Examples of opioid medications are, but are not limited to: morphine (MS Contin, Roxanol & others); codeine (Tylenol#3 & others); hydrocodone (Lortabs, Vicodin & others); oxycodone (Oxycontin, OxyIR & others); Roxicodone (Percocet, Percodan, Tylox & others); Methadone (Dolophine); meperidine (Demerol); hydromorphone (Dilaudid); hydromorphone (Numorphan); propoxyphene (Darvon, Darvocet & others), and medications that may, from time-to-time, be approved for use. This information is given to me so that I know, and therefore have the responsibility for knowing, if there are opioids in any medication prescribed for me.

I understand that a reduction in the intensity of my pain and the improvement in my quality of life are goals within this pain management program.

I understand that all medications have side effects and that I have been informed by my doctor o this potential including, but not limited to: physical dependence, pseudo-addiction, chemical dependence (addiction), constipation (which could be severe enough to require medical treatment), difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respirations, reduced sexual function, and adverse effects or injury to organs. I acknowledge that, if I take more medication that what is prescribed, I risk potentially dangerous consequences such as: coma, organ damage, or even death. I, therefore, consent to the recommended laboratory studies required to keep the medication regimen as safe as possible.

I agree that I will exercise caution and good judgment when performing activities such as driving, operating machinery, using appliances, etc.

I agree not to use any illegal substances including: marijuana, cocaine, heroin, etc.

I agree not to use the medication with alcohol or any beverages containing alcohol.

I agree not to share, sell, or trade my medication for money, goods, services, or for any other reason.

I agree that I will not attempt to get pain medication from any other health care provider without informing that provider that I am currently taking medication prescribed by my doctor at Pain Care, and I understand that to do so is against the law. If another health care provider is willing to prescribe medication, my doctor at Pain Care will first have to approve the arrangement to assure that there is no duplication. If a change is made,

Pain Care & Natural Medicine Center of Charleston – Opioid Contract – Page 2

I agree to bring any remaining pain medications in their proper containers to Pain Care to be counted and discarded before a new prescription is issued to me by another provider

I agree that I will safeguard my medication from loss or theft and further agree that failure to do so may result in my being without the medication for a period of time.

I agree that I will use _____ Pharmacy, located at: _____ _____, (Tel. No. ___ - ___ - ____, for filing prescriptions for all of my medications. If for any reason I change pharmacies, I agree that I will notify my doctor and Pain Care at the time I receive a prescription or a renewal of a prescription, and that I will advise my new pharmacy of my prior pharmacy's address and telephone number.

I agree that I will waive any applicable privilege or right of privacy or confidentiality with respect to my receipt of a prescription for opioid medication, and I authorize both my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the South Caroling Board of Pharmacy, in the investigation of any misuse, sale, or other disposition or diversion of my pain medication. I further authorize my doctor to provide a copy of this agreement to my pharmacy.

I agree that I will fully abide by the following additional rules with regard to prescriptions:

1. Prescriptions for my medication will be made in person during a scheduled office visit and only during regular office hours.
2. No prescription will be written or renewed early for any reason, including but not limited to lost, stolen, or destroyed medication.
3. No prescription will be called in over the phone to my pharmacy for any reason.

I agree that I will submit to a blood or urine test at random if directed by my doctor in order to determine my compliance with this contract and the terms herein regarding my regimen of pain control medication.

I agree to be evaluated by a psychologist or addiction specialist at any time during my treatment if requested by my doctor and if, in the opinion of the psychologist or addiction specialist, I am not a candidate for the continuation of this treatment, then I will be weaned off the medication and an alternative pain management treatment may be sought.

I understand that this medication regimen will be continued for a period of time deemed necessary and appropriate for fair evaluation by my doctor of its effectiveness. I further understand that I will be reviewed at the end of that period and, if there is no evidence that I am improving or that progress is not being made to improve my function or my quality of life, then other specific outlines of pain management may be formulated and recommended.

I agree that this contract is essential to my doctor's ability to treat me effectively, and that my failure to abide by the terms herein, may result in the withdrawal of all prescribed opioid medication by my doctor, and the possible termination of this doctor / patient relationship.

THIS AGREEMENT IS ENTERED INTO ON THIS _____ day of _____, 20_____.

_____ _____

(Patient Signature) (For Pain Care)