Skylyn Wellness Center, Inc.
Narcotic Medication Agreement

To protect your access to controlled substances and our ability to prescribe them for you, this agreement must be in place. The long-term use of opiates is uncertain. Also, the benefits of pain control with long-term use is uncertain and very controversial. With opiates and other controlled substances, there is the risk of addiction, addiction disorder, or the relapse occurring in a person with prior addiction. The accountability of these medications is a must. In order to maintain this accountability, the following rules and regulations must be agreed upon by you (the patient), as consideration for, and a condition of, the willingness of the physician to consider your initial and/or continual prescription of controlled substances to treat your chronic pain.

PLEASE INITIAL NEXT TO EACH ITEM BELOW:

1. _____You agree to take your medication as prescribed; taking medication other than as prescribed may be life threatening and is a violation of this agreement and will result in termination of pain medications given at this clinic and discharge for the clinic.
2. _____I understand that the medication(s) that are prescribed for me at this clinic may cause addiction. My physician is prescribing the medication(s) for the treatment of only my chronic pain. I understand that my treatment is initially a trial and that any continued treatment is contingent on evidence of benefit.
3. _____I understand that while I am under the care of my physician at this clinic, he/she will be the only physician prescribing my narcotic medication while I am under his/her care. An exception to this will be approved only with specific authorization and I must call my physician here at this clinic to discuss this option. A DHEC report will be reviewed at each appointment and if I am receiving narcotic medications from any other physician other than your physician at this clinic, I will be discharged from treatment at this clinic.
4. _____We must have a valid phone number with an answering machine or a cell phone with voice mail in your file prior to prescribing medications for you. In the event you are called in for a pill count, you must come the same day you are called and have the correct pill count. If we should call and find that you do not have a valid contact number, we will not be able to prescribe narcotics for you any longer.
5. _____I understand that I must bring the most current bottle/s for every medication which has been prescribed to me by this clinic to each appointment.
6. _____You must not take other opiates from other providers or individuals besides the ones we prescribe you. If you were prescribed an opiate in the past and you do not have a current prescription for it, it should not show on your urine drug screen now.
7. _____We do not accept calls for medication refills; you will be scheduled appointments at least once per month. Medications will only be refilled during those appointments. If you miss these appointments for ANY reason, you will not receive any medications until you attend your next appointment.
8. _____If medication is lost, stolen, misplaced, we do not authorize any early refills or replacement prescriptions.
9. _____You must not take Xanax, Valium or Soma from individuals. You can only take them if you have a current prescription for them from the primary care physician or psychiatric doctor.
10. _____We cannot prescribe pain medications to those who smoke marijuana or use cocaine, PCP, methamphetamines, etc., or drink alcohol, whether they state they use these substances or not.
11. _____If you plan to go out of town, you must notify this office so that we can document your absence and not try to contact you during that time. If we call and you do not respond and then use the excuse you were out of town, this will not be considered a valid reason for missing pill count.
12. _____Patients should not dispose of their medications themselves; flushing them down the toilet for example. Medications will not be replaced by us unless all pills are returned to us to dispose of them properly.
13. _____Do not expect narcotic prescriptions for more than a few months due to the risk of addiction, worsening your pain condition or compromising non-addicting pain interventions.
14. _____You agree to perform random urine drug tests, or other random drug tests, at your provider's discretion. I agree that the presence of unauthorized substances, illicit substances or the absence of medications prescribed at this clinic by my physician may result in discharge from this clinic. These tests will be performed at my expense.
15. _____You agree to use only one pharmacy and agree not to switch pharmacies without notifying this office in advance. The pharmacy listed below is where your prescriptions will be called into by phone or electronically ordered by your provider. I understand that controlled substances cannot be called into the pharmacy.

16. _____If you miss/reschedule two (2) consecutive appointments you will not receive medications again until you keep your next two (2) following consecutive appointments with our office.
17. _____I understand and agree that I will not receive any warnings if I violate any of the clauses of this agreement. If I violate this agreement I will not receive any further narcotic medications and may be released from the clinic without further notice.
18. _____ I have read the Narcotic Medication Agreement. I understand and agree with all the terms of this agreement.
19. _____ I understand that failure to adhere to these policies will be considered non-compliance and may result in cessation of any narcotic prescriptions by my physician and possible dismissal from this clinic.
20. _____ I agree to notify my physician of any new medication or medical conditions and of any adverse effects that I may experience from any of the prescribed medications.

Pharmacy Name & Store Number _____

Address _____

_____

Phone Number _____

Fax Number _____

Patient Name (print) _____

Home phone #_____ Cell phone #_____

DO NOT COMPLETE ANYTHING BELOW THIS LINE UNTIL YOU ARE WITH THE DOCTOR

Patient Signature_____Date_____

Physician Signature _____Date_____

Witness Signature _____Date_____

Copy given to patient (initial) _____ Date _____