NARCOTIC CONTRACT AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills.

2. I understand that prescription refills requested after 4:00 PM will not be received until the next business day.

3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.

4. I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.

5. I understand that narcotics and non-narcotic medications will NOT be phoned in after hours or on the weekends.

6. Patients may be terminated form the practice with 30 days' notice for noncompliance in the taking of their medications. In order to ensure compliance, Eastside Orthocare reserves the right to perform random drug screen monitoring on patients who require prescription narcotic medications over an extended period of time, as required by law. Refusal to cooperate with a drug screen likewise will constitute a basis for termination from the practice.

7. Eastside Orthocare will NOT refill prescriptions that have been lost or misplaced.

8. I must keep all appointments as recommended.

9. I will not give away, trade or sell medications.

10. The following are specific (but not exclusive) grounds for immediate termination from the practice: 1) Obtaining narcotics from any other physician while under Eastside Orthocare's care. 2) Altering or forging of a prescription. *This is a felony and will be reported.*

11. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a DUI.

12. I will not combine any narcotic medications with the consumption of alcohol.

13. I understand that only one pharmacy may be used for filling any prescriptions. My pharmacy's name and location is:_____

_____

(Please notify us if you change pharmacies) Pharmacy's Phone Number: _____

I have read, understood and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe narcotic medications to treat my pain. I acknowledge having been provided a document entitled Controlled Substance Agreement and Informed Consent Form and I have a right to a paper copy upon request or can obtain a copy on the Eastside Orthocare website at www.eastsideorthocarega.com and have the opportunity to ask questions and receive answers to my satisfaction.

Patient Name *(please print):*_____ Date of Birth:_____

Patient Signature:_____ Date:_____