Anyone receiving chronic controlled substances from OKLAHOMA SPINE DIAGNOSTIC & PAIN TREATMENT CENTER will have to sign a Medication Usage Agreement.

By signing this agreement I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to abide by the following conditions and terms when using any and all medications prescribed to me by the staff at this practice:

1. I will take my medication(s) only as directed. Any changes in taking my medication(s) will need to be discussed with the office practitioners prior to the change.

2. I agree to take full responsibility for my medication(s) and understand that:

a. Lost or stolen medications will not be replaced.

b. I will not share my medication(s) with anyone.

c. Early refills will not be given if I have accelerated my medication usage and run out before I am due another refill.

3. State law prohibits obtaining medications under false pretenses. If this occurs, we are obligated to report these situations to local law enforcement agencies. Misuse or abuse of these medications is a Class D felony. If the below occurs we will be required to discharge you from the practice immediately. Such false pretenses include, but are not limited to:

a. “Doctor shopping” to obtain multiple prescriptions.

b. Multiple emergency room visits to obtain prescriptions and medications.

c. Use of false identification or any other subterfuge in order to obtain medications.

4. It is important that patients receive their medications from only one doctor.

 This is not only to prevent possible legal penalties, but also to avoid dangerous side effects and interactions that your medication can have with other medicines that we may not be aware that you are taking. Therefore if you receive any medication(s) from another treating physician, it is imperative that you let us know what these medications are.

5. Please be aware that it is not a medical obligation to prescribe controlled substances to a patient at any time.

6. We strongly encourage all of our patients to refrain from using tobacco and alcohol. We also strongly discourage the use of illicit drugs – either illegal substances or prescription medications that are bought from illegal sources.

7. I understand that random urine and/or serum drug testing and random pill counts are done at OKLAHOMA SPINE DIAGNOSTIC & PAIN TREATMENT CENTER. I understand that failing a random drug test can be defined as:

a. The presence of illegal drugs in the sample.

b. The presence of legal drugs that should not be in the sample.

c. The absence of the drugs we prescribe when there should be evidence of that particular medication.

d. Attempting to pass off someone else’s sample as my own.

e. Attempting to alter the sample that I leave in order to disguise the results.

8. I understand that refusing or failing a random drug screen may result in one or more of the following occurring:

a. I may be required to repeat the screen.

b. I may not be prescribed any medications.

c. I may be discharged as a patient.

d. I may be referred to a drug rehabilitation program.

 9. I understand that requests for medications and/or refills are done as follows:

a. Refills may be requested Monday through Friday from 8:30am until 3 pm.

b. Refill requests generally take 5 business days to process.

c. No refills will be done on weekends, after normal business hours or on holidays. There will be no exceptions.

d. All controlled substances received from our office must be written on a prescription. These medications will not be called into pharmacies.

10. Since the drugs may be hazardous or lethal to a person that is not tolerant to its affects, especially a child, you must keep them out of the reach of such people.

11. I realize that is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by Dr. Khan.

12. I understand that strong medications, which may include opiates and other controlled substances may be described for pain relief. I understand that there are potential risks and side effects with taking any medications, including the risks of addiction. Overdose of opiate medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opiate pain killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.

13. I realize that all medications have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long-term use of substances prescribed.

14. (**Males only**) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal.

15. (**Females only**) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and/or primary care provider and OSD&PTC office to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I am aware that the u se of opioids is not generally associated with the risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking opioids. The child could be physically dependent on the opiates and withdrawal can be life threatening for a baby. If a female of child-bearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with medications from OSD&PTC.

16. Changes in prescriptions/refills will be made only during scheduled appointments and not via phone, at night, on weekends or holidays. This policy will be strictly adhered to.

17. I agree to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pharmacy located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for all of my controlled substances.

If I change my pharmacy for any reason, I will notify the practitioner at the time I receive my prescriptions. If you have any questions or concerns about this policy, please do not hesitate to discuss it with Dr. Khan.

I have read the above agreement and agree to abide by the terms set above.

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Patient Name (Printed) Date

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 Patient Signature Witness Signature