



**Baher Yanni M.D. Ashraf Sakr M.D. Samir Jani M.D.
Amanda Morris PA-C Payal Patel PA-C**

Opioid (Narcotic) Contract

The purpose of this agreement is to prevent misunderstandings about certain medications you will take for pain management. I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines. In this case, my doctor will taper off the medicine over a period of several days, if necessary, to avoid withdrawal symptoms. Also a drug dependence treatment program may be recommended.

- I will communicate fully with my doctor about the character and intensity of my pain, the effects of the pain on my daily life, and how well the medicine is helping to relieve the pain;
- I understand that narcotic and controlled drug prescription is **My Responsibility** once they are placed in my hand. I understand that if anything happens to this prescription (i.e. it is lost, stolen, flushed down the toilet, etc.) I am personally responsible and the physician or/and physician assistant or/and nurse practitioner will not rewrite the prescription until the designated time is given.
- I will not use any illegal controlled substance, including marijuana, cocaine, etc.
- I will not share, sell or trade my medication with anyone;
- I will not attempt to obtain any controlled medicines, including steroid pain medicines, controlled stimulants, or anxiety medicines from any other doctor;
- I will safeguard my pain medicine. I understand that this medication may be lethal or hazardous to a person that is not tolerant to its affects, especially a child.
- I agree that refills on my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends and 72 hours notice should be given to my provider before a refill is needed;
- I authorize my doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also agree to only use one pharmacy;
- I understand the possible adverse effects and dependencies associated with this medication. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing, sexual dysfunction, and or depressed respiration.
- I agree that I will submit to a urine test when requested by my doctor to determine my compliance with my program of pain control medicine. Additionally, I agree to bring my medication to each visit for use in random pill counts to ensure compliance.
- I understand that if I plan to become pregnant or become pregnant, I have to inform the physician or/and physician assistant. I understand that if I become pregnant, a child will likely be physically dependent at birth if I continue narcotics.
- I realize that it is my responsibility to keep others and myself from harm, including safety of driving and the operation of machinery.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. All of my questions and concerns regarding treatment have been adequately answered. A copy of this Agreement will be given to me and to any physician with whom I seek treatment from.

PATIENT SIGNATURE _____ DATE: _____

WITNESS _____ DATE: _____