KIRSHNER
Spine Institute

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Medication Agreement/Policy

I, (Name) _____ understand that I am entering into an agreement between myself and Kirshner Spine Institute and all clinicians employed within. The policy is as follows:

No unauthorized adjustment: I will take my medications exactly as prescribed and will not change the dosage or schedule without my clinician's approval. No early refills will be given in the case of unauthorized adjustment of medication.

Other treatments/Discontinue treatment: I will participate in other treatments that my clinician recommends and will be ready to taper or discontinue if I am non-compliant or other effective treatments become available. I understand that my treatment will be discontinued if I give away, sell, interchange, or misuse the medication. If the clinician does not feel that narcotic is improving function, medication treatment may cease.

Communication: I understand that my usage of narcotic medications will be communicated to the referring physician, family physician and/or pharmacy on a regular basis.

One Clinician: All opioid and other controlled drugs for pain must be prescribed by one physician. I will not obtain medications from other clinicians unless I am hospitalized or a medical emergency. I will not omit that I am receiving pain medications to other providers.

One pharmacy: I will designate one pharmacy where all my prescriptions will be filled. If I change my pharmacy for any reason, I will notify the above practice. Pharmacy:_____

Lost/Stolen prescriptions/medication: I understand that medication that is lost or stolen will not be replaced. Allowing controlled medication to be lost/stolen is a serious lapse in judgement and I may be discharged from the practice.

Refill policy: All medication will be filled during office visits only. It is your responsibility to make a follow-up appointment before your medication runs out. No prescriptions will be called in or mailed.

Strict monitoring: I agree to random drug testing via methods including saliva, urine, blood or hair for the purposes of determining compliance with the use of my pain medications and to determine if I am using illegal controlled substances (e.g. marijuana, cocaine, PCP, methamphetamine). My misuse, unauthorized use, or abuse of any medication, prescribed or illegal, will cause me to be immediately discharged from the practice, and my care will be transferred back to my PCP at their discretion. If Kirshner Spine Institute finds that I have misused any substance they will provide me with the information for drug treatment facilities that I may contact on my own if I feel necessary.

Signed:_____ Date:_____

Provider:_____