OPIOID/CONTROLLED MEDICATION AGREEMENT

As part of your pain treatment, Bryan X. Lee, MD and/or his associate(s) may prescribe opioid ("narcotic") or other controlled medications (e.g. benzodiazepines). **This agreement applies only if you are seeing Dr. Lee and/or his medical associate(s) on a REGULAR basis and prescribed OPIOID/CONTROLLED medications.** If you are **transferred/discharged back** to your primary care or another healthcare provider, then follow the guidelines set forth by him/her. By signing below, the patient agrees to the following:

I will take the pain medications exactly as prescribed, will not change the dosage or schedule, or mix with other controlled substances/medications without my doctor's approval. I understand that controlled/pain medications, especially if misused, can lead to complications, **including respiratory arrest, heart failure, stroke, paralysis, coma, and death.**

I will keep regular appointments and call at least 24 hours in advance if I need to reschedule. There may be no early refill of medications. Refills will only be honored during office hours, not weekends, holidays or evenings.

I will only obtain my controlled pain medications from Dr. Lee and/or his associates. I will not obtain medications from other clinicians unless I am hospitalized or go to the emergency room, in which case I will inform the doctor(s) that I receive pain medications from this practice. In an emergency, if I am given a pain prescription, I will notify this practice as soon as possible.

I will only use one pharmacy for my pain medications. Lost or stolen prescriptions may not be replaced. I understand there may be no early refills. I agree the pain medications are only for my personal use. Diversion (e.g. selling), abuse, or addiction to the opioid/controlled medication(s) may lead to discontinuation of opioid medication(s) and/or referral to treatment.

I agree to abstain from excessive alcohol use and illegal and recreational drug use and will provide urine or blood samples at the doctor's request. Presence of illegal drugs or non-prescribed drugs, or noncompliance to drug testing may lead to termination of the doctor-patient relationship.

I give permission for Dr. Lee and/or his medical associate(s) to communicate with other healthcare professionals, family members, law enforcement, and/or regulatory agencies regarding my pain treatment only if necessary.

Opioid medication may have side effects, including **drowsiness, confusion, constipation, nausea, vomiting, and urinary difficulties**. I will not drive or use heavy machinery if I am drowsy from the medication(s). These medications, if stopped abruptly, may cause withdrawal symptoms including diarrhea, goose bumps, sweating, anxiety, and abdominal cramps.

I understand that violation of any of the above conditions may result in Dr. Lee and/or his associates discontinuing the use of opioid or other controlled medications, as well as termination of the doctor-patient relationship. My questions have been answered to my satisfaction and I agree to the above guidelines.

Name	Signature (Patient, Parent or Legal Guardian)	Date

PENALTY FEES

By signing below, the patient acknowledges that s/he may be charged a "no show" fee for a missed appointment OR not canceling an appointment 24 hours in advance. The fees shall be at least **$50** for a missed office appointment, and at least **$150** for a procedure appointment (at surgery center or office). There is a fee of at least **$25** for a "bounced check".

BLOOD THINNER DISCLOSURE

As part of your pain treatment, you may have to undergo procedure(s) (e.g. spinal injections). If you are taking blood thinners, you may have to stop them for a period (e.g. 5-7 days). Stopping these medications (e.g. Aspirin, Warfarin, Clopidogrel, Cilastazol, Ticlopidine, Dabigatran, dipyridamole, etc) can increase the risk for **complications, including blood clots, stroke, heart attack, pulmonary embolism, respiratory failure, paralysis, and death**. You need to consult with your prescribing doctor to determine if you can stop your blood thinner(s). By signing below, you attest that you understand the above risks and will consult with your prescribing doctor before discontinuing these medications.

Name	Signature (Patient, Parent or Legal Guardian)	Date

Internal Office Use: Witness Signature:_____ Date:_____

*****TWO-SIDED FORM (Complete Other Side)*****