River Cities Bone and Joint Centre

PRESCRIPTION POLICY

The purpose of this agreement is to prevent misunderstandings about certain medicines you may be taking for pain management. This is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

- I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement
- **I understand that if I break this agreement, my provider will discontinue prescribing me any or all medications**
- I will not use any illegal substances, including Marijuana, cocaine, etc.
- I will not share, sell, or trade my prescribed medications with anyone.
- I will not attempt to obtain any prescriptions, including Opioid pain medicines, controlled stimulants, or anxiety medications from any other source, ***including the ER***, unless I discuss it first with my provider.
- I will safeguard my medication from loss or theft. Lost or stolen medication will not be replaced.
- I understand that medication refills are made **only** during regular business hours, and according to my pain medication schedule given at the time of surgery with **NO EXCEPTIONS**.
- I understand that controlled substances may have adverse side effects such as but not limited to drowsiness. Any questions, concerns and precautions I may need to take I understand I will need to speak to my local pharmacist about. Each prescription comes with a list of side effects and I accept the responsibility to read them carefully.
- I agree to use _____ Pharmacy,
- located _____,
- Telephone Number_____, for filling my prescriptions for **ALL OF MY PAIN MEDICATION**.
- I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency.
- Kentucky law requires our office to obtain a KASPER report prior to prescribing any and all controlled substances. **I understand once the report is obtained, if the report indicates I am being prescribed a controlled substance from any other provider Dr. Leith will NOT prescribe me any further medication.**

This agreement is entered into by:

_____

Patient / Representative Signature **Date**