NARCOTIC CONTRACT

Name (Last, First): ____ Date of Birth: ______ / ______ / ___________

I understand and agree to the following rules and conditions regarding refills of prescribed medications:

The medication(s) covered by this agreement include:

Medication	Strength	Direction	Quantity Per Month

1. I will limit my dose of medications to the dose prescribed. I will discuss any future dose changes with my provider.
2. I am responsible for my medications. Lost, misplaced, or stolen prescription medications will not be replaced.
3. Refills will be made only at the prescribed level. No early refills will be authorized.
4. No refills will be authorized after hours, on holidays, or on weekends.
5. I will obtain all refills for these medications only at ____ (Pharmacy)
6. I will request all refills through __Keeran Kumar, MD__ during these hours: __9:00am – 4:00pm__
7. I understand that my provider may stop prescribing narcotic medications or change the treatment plan if I do not show any improvement in pain from narcotic medications or my level of activity has not improved.
8. I understand that my pain medication may cause drowsiness and alcohol may intensify this effect. I need to use care when operating a car or dangerous machines.
9. I will not get any other opioid pain medicines or other medicines that can be addicted such as benzodiazepines (for anxiety or sleep), or muscle relaxants, without telling my doctor.
10. I agree to give a urine sample if asked to test for drug use.
11. I understand that failure to comply with any of these conditions or failure to make regular follow-up appointments with my treating physician may result in termination of prescriptions for the medications listed above. I am aware that my physician may discharge me from his/her practice, and that my health plan may discharge me for narcotic fraud or abuse.

This agreement is entered on the date signed below and is valid for 12 months unless otherwise specified.

Print Name: ____ **Signed:** ____

DATE: _____ / _____ / ___________