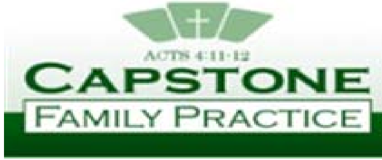

Dr. Andrew Spafford
Dr. Tina Corkran
Dr. Grace Lee
Abigail Allen, P.A.
Leah Lopez, N.P.

MEDICATION AGREEMENT

I WILL NOT:

I will <u>not</u> see any other physician for my medication(s) including any other "Pain Management" type physician while under the care of this group. All my medication(s) from this clinic cannot be obtained from any other source. In the event of an acute case (dental work or surgical procedure), I must notify my physician in advance.

I will <u>not</u> use alcohol or illegal controlled substances (cocaine, marijuana, etc.) I have been made aware of the dangerous side effects of narcotic and tranquilizer use alone or in combination with other substances. Thus, I absolve the physicians and staff of any willful negligence.

I will <u>not</u> share, sell or trade my medication(s) or prescription(s) with anyone.

I will <u>not</u> attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, Soma, barbiturates, or anti-anxiety medicines from any other doctors unless approved by my physician in advance.

I WILL:

I <u>will</u> provide the physician and staff with all my medical records pertaining to my past treatment. I understand that failure to provide such information gives the clinic the right to refuse to treat me.

I <u>will</u> be responsible for my pain medicine, keeping it safe from loss or theft. Lost medications will NOT be replaced. Stolen medication will not be considered for refill until a police report is filed and sent to the doctors' attention.

I <u>will</u> use my medicines at the rate they are prescribed. If I use my medicines at a greater rate, it will result in my being without medication for a period of time. Physicians will NOT authorize any early refills under any circumstance.

I <u>will</u> use only one pharmacy to fill my medications. I agree to use ______________________________________Pharmacy,

located at ____ for filling prescriptions for all my pain medications.

Pharmacy telephone number ___________________________________

Potential side effects are ____.

I <u>will</u> agree that no refills will be available during evenings, weekends, or holidays.

I <u>will</u> agree to authorize the doctor and the 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 or sale, etc. of my pain medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.

I <u>will</u> submit to a blood or urine test if requested by my doctor, and I will have an annual physical.

I <u>will</u> adhere to my provider's follow up appointment requirement. No temporary refills will be approved.

I understand all the policies above and my signature below states my agreement to comply. I am aware that if I breach this agreement, then Capstone Family Practice holds the absolute right to discharge me as a patient.

Patient name ____ **Date of birth** _________________________

Signature ____ **Date** ___________________________