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Opioid Medications Patient Agreement

I _____ will carefully read and observe the following rules and conditions regarding opioid use and restrictions. If any of the rules are broken, you will be dismissed from the practice.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is _____.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

Patient's signature

Date