ASHEVILLE ORTHOPAEDIC ASSOCIATES
AN AFFILIATE OF MISSION HEALTH

Acct #:_____

Medication Treatment Agreement

Please make sure to read this agreement in its entirety and sign below. The purpose of this agreement is to prevent misunderstandings about certain medicines you could be taking for pain management. This is to help you and your physician comply with the state and federal laws regarding controlled pharmaceuticals.

I authorize the physician and my pharmacy to cooperate fully with any law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize my physician to provide a copy of this contract to my pharmacy. I agree to waive any applicable privilege to right of privacy or confidentiality with respect to these authorizations.

I understand that if I violate the agreement, my physician may stop prescribing these pain-control medicines, discharge me from the practice, and may also inform my referring physician, medical facilities, and other authorities.

I will communicate fully and truthfully with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substance, including marijuana, cocaine, methamphetamine, etc.

I will not consume alcoholic beverages while on this medication, without further discussion with my provider.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines **from any other health provider.**

I agree that refills of my prescription for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings, weekends, or holidays.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. I understand that I will not be able to obtain early refills.

Females only: If you plan to become pregnant or believe you may already be while taking this medication, your obstetrician must be notified immediately and this office must be informed.

I understand that if I require chronic pain medication, I will be referred to a pain specialist for medical management.

I understand that a photo ID is required to pick up my prescriptions.

Patient Signature: _____ Date: _____

Witness Signature:_____
Asheville Orthopaedic Associates Staff

Prescription History Waiver:

By signing below I give permission for Asheville Orthopaedic Associates, PA to view my external prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back in time for several years.

By signing below I understand and agree to call this office for pain medication refills between 9:00 AM – 5:00 PM Monday thru Friday during regular business hours.

Patient Signature: _____ Date of Birth: _____

Witness Signature: _____ Date: _____
Asheville Orthopaedic Associates Staff