



NOBLE

PAIN MANAGEMENT
& SPORTS MEDICINE

Patient Name: _____

Date of Birth: _____

Therapeutic Agreement for Controlled Substance Medication Prescriptions

Both Noble Pain and Sports Medicine (Noble) and I (the “Patient”) have a common treatment goal: to improve my ability to function and/or work. In consideration of that goal, I will be treated with potent medications. I understand that some of the medications will be narcotics, tranquilizers and/or barbiturates. I understand that these medications are considered controlled substance medications and their use is closely controlled and monitored by the local, state and federal agencies. I have been informed that these medications are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse. I also understand that these medications have the potential for various side effects and the side effects will be explained to me prior to treatment.

I have been fully informed by Noble’s physicians and staff about psychological dependence (addiction) to controlled substances. If this happens to me, I agree that I will promptly notify Noble of my addiction and I agree to follow the Noble physician’s guidance and participate in any treatment program prescribed which may include detoxification, psychological counseling, and medical treatment. I understand that my failure to comply with the Noble physician’s guidance and recommendations may result in the termination of my relationship with Noble.

In light of the foregoing, and as a condition to Noble prescribing controlled substance medications to me, I agree to abide by the following:

1. A baseline drug screen may be obtained and completed on the first and/or subsequent clinic visits.
2. I agree that all controlled substance medications and prescriptions shall be prescribed only by Noble.
3. I understand that obtaining and taking controlled substance medications from any individual or physician other than Noble will be considered a violation of this agreement. The only exception is medications prescribed while I am admitted to the hospital.
4. I agree that in the event I obtain and take controlled substance medications from any individual or physician other than Noble, I will promptly (no later than my next clinic visit) inform Noble of the details.
5. I will take the medications as prescribed by Noble as directed, no more and no less. If I use up my medications sooner than prescribed, I understand that they will not be replaced.
6. I understand that if I have any unused medication, the medication needs to be brought into the office for the purpose of supervised disposal.
7. I understand that some patients may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. I also understand that as a result of other treatment modalities or the natural course of my disease process, my pain may decrease. Therefore, I recognize that my medication doses will have to be adjusted (increased or decreased) as deemed appropriate by my Noble physician. I agree that I will not adjust the medications by myself.
8. I understand that if I stop taking the medications abruptly this may be dangerous and lead to withdrawal symptoms. I agree that if the medications need to be discontinued, I will do so gradually and only under medical supervision.
9. I acknowledge that I am responsible for my controlled substance medications. I agree that if my medications or prescriptions are lost, misplaced, stolen or disappear for any reason, they will not be replaced. I further agree that in such an event, I must promptly contact and notify the Noble staff regarding the loss of my prescriptions or medication immediately. I understand that a police report is required for replacement of lost or stolen medications.

10. I understand that I am responsible for keeping track of the amount of the medications left and for scheduling an appointment in advance for the refill of my prescriptions so I will not run out of medications.

11. I agree to use:

_____ pharmacy, located at _____ phone number

_____ for all my pain medications. I further understand that:

a. Request for refills will be addressed at monthly office visits. **Refills will not be made at night, on holidays, or weekends.** I understand that refill requests after regular office hours will not be prescribed or refilled because such requests could suggest inappropriate opioid usage.

b. Refills may be delayed as a result of drug screen results.

12. I understand that Noble may perform random drug screens on me at any time, in the sole discretion of Noble, and that I may be financially responsible for the costs associated with the random drug screens. Failure to complete random drug screen within 24 hours will be presumed positive and the doctor may choose to terminate the relationship at that time.

13. I understand that Noble reserves the right to obtain my external prescription history.

14. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

15. I agree that I will not, at any time, use any illegal controlled substances, including marijuana, cocaine, etc.

16. I agree to help myself by trying to change my behavior towards a healthier lifestyle including: stop smoking, use of alcohol only in moderation as permitted by my physician, diet and weight control and exercise. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

I understand that if I violate any of the above conditions, my relationship with Noble (including my right to receive controlled substance prescriptions) may be terminated.

Patient Name (signed): _____

Patient Name (printed): _____

Witness: _____

Date: _____