SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER
MEDICAL GROUP, INC.

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Controlled Substance Agreement

I understand that my provider is prescribing controlled medications (opioids, barbiturates, benzodiazepines) to assist me in managing my post-operative pain. These medicines are intended to decrease pain in order to improve function and allow progress in rehabilitation. As the user of these medications, I understand that I have important responsibilities regarding the care and use of these medications. The risks, benefits, and side effects of these medications have been explained to me and I agree to the following conditions for this type of treatment.

1. I understand that I should be receiving pain medication from only one doctor or practice at any one time. I understand that I will only be getting prescriptions for pain medicines from Dr. Aryan (or his PA's) at Sierra Pacific Orthopedic and Spine Center or from a physician outside of the practice, but NOT BOTH. If I develop another condition that requires the prescription of a controlled medication, I will inform the clinic within one business day of receiving any new controlled medications.

2. I understand that Dr. Aryan may only be prescribing my pain medications up to **90 DAYS** past the date of my surgery. At that point, if they are still necessary, I will receive them from my PCP or a dedicated pain management physician.

3. I will designate only one pharmacy where all of my narcotic prescriptions will be filled.

4. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my provider's approval. Refills may not be given if I "run out early".

5. I understand that I am responsible for the care of my medications once I leave the office/hospital with my prescription. I understand that my narcotic medications may not be replaced if they are lost, stolen, or destroyed. Controlled medications should be locked up and secured.

6. Refills of controlled medications will be made only during regular office hours.

7. I understand that the medications prescribed are for the sole purpose of pain control and agree not to use it for any other purpose.

8. I will not share or divert my narcotic medications with any other person.

9. I understand that controlled medications can affect my thinking and judgment and may interfere with my ability to drive. I will not drive if I have this concern.

10. I understand that my physician may use a prescription monitoring program to keep track of my medications.

I understand these rules and that noncompliance may lead to the discontinuation of my medications and/or discharge from Dr. Aryan's care. I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any application or right of privacy or confidentiality with respect to these authorizations.

I have read the contract and it has been explained to me. I fully understand the consequences of violating this agreement.

_____ _____ _____

Patient Signature Date Witness