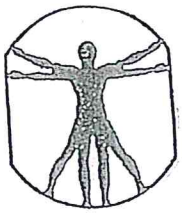

Mid-America Orthopedic & Spine Institute, LLC.

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. Narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. They are intended to relieve pain to improve **FUNCTION** and/or ability to work, **NOT** simply to feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, damaged, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual without approval of Dr. Bailey while I am receiving such medications from Dr. Bailey. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.
3. I will get my controlled substance medications filled at only one pharmacy. If your insurance plan dictates change of pharmacies, I must be notified, and all future prescriptions will be obtained at that new single pharmacy.
4. There will be no change in my prescription by telephone. I agree to appear in person and **will not** be allowed to change the dosing without prior authorization.
5. **Refills** of controlled substance medication:
    a. Will be made only during regular office hours. Monday through Friday. Refills will not be made at night, weekends, or on holidays.
    b. Will not be made if I "run out early" or "lose a prescription", "spill or misplace my medication," or "have my medication stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    c. Will not be made as an "emergency" such as on Friday afternoon because I suddenly realized I will "run out tomorrow." **I will call my pharmacy and or the doctor's office at least (24-48) hours in advance for all refill requests**, and/or if I need assistance with any medication prescription.
    d. I agree to see Dr. Bailey in his office on a monthly basis or less than a month if directed by Dr. Bailey to do so to obtain the prescription.

6. I understand that driving a motor vehicle must be monitored at times while taking controlled substances and that it is my responsibility to comply with the laws of this state while taking the medication prescribed.

7. I agree to have a random drug screen performed at any time at the request of Dr. Bailey. I agree that I may be subject to pill counts at Dr. Bailey's office within a reasonable amount of time from the notification that a pill count is to be performed. If I fail to appear in a reasonable amount of time on the day the pill count is to be performed and prior to the close of normal operating hours at Dr. Bailey's, that I am subject to dismissal from his care.
8. I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. I understand that it is not appropriate for me to attempt total relief of the pain with the use of opioid medications. To do so places me at risk of respiratory depression, sedation, nausea, constipation, and tolerance. A 50% reduction in pain is a realistic goal. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, avoiding the use of tobacco and alcohol. I understand that I must learn new pain management strategies and will strive to increase my activities. I must also comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
9. I understand the goal in prescribing pain medications is to reduce the need for them in a reasonable amount of time. For example, the underlying pain may decrease over time, and I should attempt to learn safer ways to manage my pain (e.g., relaxation techniques, self-hypnosis, biofeedback, exercise program, etc.)
10. I understand that **if I violate any of the above conditions**, my controlled substance prescriptions and/or treatment will be ended **IMMEDIATELY**. Unethical behavior will be grounds to discontinue care of you (e.g., diversion or selling opioids to others or taking opioids for emotional reasons). If violation above, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to my physician, medical facilities, and other appropriate authorities.

I have been fully informed by Dr. Bailey regarding psychological dependence (addiction) of a controlled substance, which I understand is rare. I know that some people may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect, and I know and understand that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms. By signing this agreement, I give Dr. Bailey the right to contact their physicians or pharmacies concerning the use of the narcotics.

I have read this agreement and the same has been explained to me by Dr. Bailey. In addition, I fully understand the consequences of violating this agreement.

_____	_____	_____
Date	Patient's Signature	Signature of Witness