

DELAWARE NEUROSURGICAL GROUP, P.A.

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Narcotic Agreement and Prescription Refill Policy

Please thoroughly read the following policy and agreement and sign if you agree to these terms. Please note, we will be unable to complete your request for narcotic medications unless the agreement is signed. Our goal is to provide optimal patient care. Your thorough understanding of our policy and narcotic agreement will help us continue to do this. Thank you for your cooperation.

Patient Name: _____ **DOB:** ____/____/____

The following agreements are made between the Patient and Provider, as identified above, and outlines the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

PAIN MANAGEMENT PATIENTS: This agreement does not replace the agreement/contract you have with your pain center. Delaware Neurosurgical Group does NOT provide long term opioid therapy. We will prescribe narcotic pain medication for a maximum of 30 days following surgery for acute postsurgical pain. Depending on your pain management practice, accepting a narcotic prescription from Delaware Neurosurgical Group may violate your agreement despite undergoing recent surgery. It is imperative that you inform your pain management specialist of your surgical date and discuss a postsurgical pain management plan. A follow up visit after surgery with your pain management specialist should be arranged in advance and in addition to your scheduled postoperative visit in our office.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- Narcotic Medication(s) for the management of my acute pain following surgery will be provided by my provider so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement will result in discontinuation of the medication(s).
- Narcotic medications will only be prescribed during the initial portion of your post-operative recovery period. If you require narcotic medications longer than this period, a pain management referral will be arranged.
- I agree to take pain medications/controlled substances only at the dose and frequency prescribed and understand NO early refills will be authorized.
- I will not receive pain medication prescriptions from any other healthcare provider and understand that there will be no replacement for any medications that are lost or stolen. Furthermore, if my medications are lost or stolen a re-evaluation of my competence to continue on these medications may be performed.
- I will obtain all medications from one pharmacy and will provide my pharmacist with a copy of this agreement at the request of my provider.
- I understand that there will be no prior authorization for controlled substances.
- I understand that a drug history report will be obtained prior to providing any and all narcotic prescriptions to verify compliance and give permission for Delaware Neurosurgical Group to discuss my pain medications with pharmacies, hospital emergency rooms, or other physicians involved in my care.
- I authorize the practice and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Delaware 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, other treating physicians, and emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

- I will not use any illegal controlled substances, including marijuana, cocaine, etc. nor will I misuse or self-prescribe/medicate with legal controlled substances or alcohol.
- I will consent to undergo random unannounced checks for drugs on less than 24 hour notice and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or the absence of authorized medication(s) may result in these medications being discontinued and termination of the prescriber/patient relationship.
- I agree to bring my pain medication into the office to be counted if requested.
- I will not share, trade or sell my medication for money, goods or services. I understand that these are prosecutable offenses and may be reported to the authorities.
- I am required to keep my healthcare provider up to date on all medications that I am taking.
- I will comply with the following office refill policy:
 - I understand refills of my prescriptions should be addressed in person at scheduled office visits.
 - I will not stop by the office without an appointment and I understand I will not be seen and refills will not be addressed without an appointment.
 - Refills may not be made nights, weekends or holidays.
- I understand all narcotic medications must be handwritten and cannot be called into my pharmacy.
- I understand that this office does NOT provide long-term opioid therapy.
- I understand these medications are to be used to decrease my pain but they will not take away my pain completely. These medications are to be used to help improve my ability to perform activities of daily living including bathing, dressing, toilet hygiene, transferring, walking, etc. If these medications do not help me meet those goals, they will be discontinued. A distinct clinical syndrome, “hyperalgesia syndrome”, has been described in the literature and can actually result in increased pain from continual and escalated doses of opioid medication.
- My physician may at any time choose to discontinue the medication(s) for the treatment of my condition.
- I understand that this agreement is essential to the trust and confidence necessary in a healthcare provider/patient relationship and that my healthcare provider undertakes to treatment based on this agreement.

This agreement is entered into on ___/___/___ **between** _____ **and**
Delaware Neurosurgical Group. *Patient Name (Printed)*

Patient Signature: _____

This agreement will remain in effect from the date of the written signature and does not expire.