Today's Date _______/_______/________

Scottsdale Location	Mesa Location
8630 E. Via De Ventura	3130 E. Baseline Rd.
Suite 201	Suite 101

Opioid Chronic Pain Management Contract

Patient Name: ____
Pharmacy Name and Location/Address: ____
Pharmacy Phone/Fax: ____

"This agreement is between the above named patient and Stefan D. Tarlow, M.D. Opioid medication prescriptions will be written for you when the following terms are met:

1) You must take the medication we prescribe **exactly as instructed** by the provider.

2) If at any time you are obtaining pain medications or attempting to obtain such drugs from another source **WITHOUT** our knowledge, you will be **DISCHARGED** from our care. You will also be released if you are found to be taking Narcotic (illicit) substances.

3) You must designate **ONE** pharmacy for your opioid pain medication. Having multiple pharmacies or other physicians prescribing opioid medication unbeknownst to Dr. Tarlow is grounds for discharge from our care.

4) In order to continue to receive medications, you must **MAKE** and **KEEP** scheduled appointments with Stefan D. Tarlow, M.D..

5) Pain medication should be kept in a safe place. Opioid medication **LOST, STOLEN, DESTROYED** or missing for any accidental reason will not be replaced. Opioid prescriptions **WILL NOT** be refilled early.

6) Phone calls regarding medication will be made **Monday through Friday** prior to **2 pm** to give office staff ample time to call in all patient requests. **NO** drug refill requests will be granted **AFTER** hours or on **WEEKENDS.**

7) If at any time you are concerned about your medication or side effects of your medication, you may call the office or through the exchange after hours.

8) You understand that these medications may create a physical dependence and you are **willing** to **ACCEPT** that responsibility. State law **prohibits** the **driving** under the influence of opiate medications

9) The physician will be decreasing your narcotic medication in a stepwise progression to a lower potency in a reasonable time frame based on your diagnosis. If managing your pain is beyond the scope of practice you **will** be **referred** to pain management.

10) If requested by your insurance carrier, all information will be released to the company. If required by the Drug Enforcement Agency regulations, your diagnosis may be revealed at the pharmacy. We may contact ANY pharmacy or physician regarding your medications.

11) You understand that the medications that are prescribed for you are for your use **ONLY**. You understand that State and Federal laws prohibit the sale of or sharing of prescription medications. Such behavior will not be tolerated and result in our office notifying the **DEA**. This will also be grounds for discharge from care.

12) Post operative and chronic pain issues will be managed for a maximum of 3 months from the date of this contract. IF opiods are needed beyond this point, you will need to seek out your primary care physician or a chronic pain management physician. The office can assist in finding a chronic pain management specialist in your area.

13) Periodic Drug Screening of blood, urine or both will be conducted at the initiation of this contract and on a regular schedule during the contract period.

14) By signing this agreement, you are agreeing to **ALL** of the above terms. You understand the expectations as a patient regarding the use of the prescribed medication. You understand that failure to comply with Any and All of these terms will void this contract.

____ ____________________
Patient Signature Date

____
Physician Signature Date