



SPINAL AND ORTHOPAEDIC MEDICINE ASSOCIATES

DIAGNOSIS & TREATMENT OF SPINAL & ORTHOPAEDIC MEDICINE DISORDERS

OPIOID MANAGEMENT AGREEMENT

This opioid management agreement is entered between _____ and the physicians(s) of Spinal & Orthopaedic Medicine Associates. The purpose of this agreement is to establish relies for the use of opioid medications and their safe use and appropriate prescribing.

Violation of this opioid agreement will result in dismissal form the pratice

1. I will receive my opioid medications only from physicians employed by Spine, Sports & Industrial Rehabilitation/Spinal & Orthopaedic Associates.
2. I will take my pain medications as prescribed and will not alter how I take these medications unless instructed by my physician.
3. I will attend all scheduled appointments with the physicians or to practitioners to which I have been referred.
4. I will avoid alcohol and illegal drugs while I am taking narcotics.
5. I will allow my physicians to contact my family, friends and other treating practitioners for their assistance in managing my conditions and the use of my medication.
6. I will only call for prescriptions refills that are due, during office hours Monday through Thursday 9 am to 4 pm. I will not request prescriptions on Fridays, or evenings, weekends or holidays.
7. I will notify the office of a need for a refill on a medication no greater than five (5) days before it is due.
8. I understand that I ma be required to personally pick up any prescription refills at the discretion of my physician.
9. I will not sell or give my opioid medications to other individuals.
10. I am willing to take a random drug screen at the request of my treating physician. If my drug screen is not covered by my insurance company, or other payer source, I agree to pay for the testing myself.
11. I will not take my opioids or operate equipment if they impair my ability to concentrate and think clearly, produce dizziness or drowsiness. I will notify my physician of this information.
12. I understand that if I take opioid medications for a long period of time, this can result in physical dependence. This means that if I stop taking my medication suddenly, I may experience withdrawal symptoms, such as watering eyes, runny nose, sweating, tumors, joint pain, difficulty sleeping, agitation, diarrhea, and abdominal pain. I will notify my physician if this occurs.
13. I understand that taking opioids over a long period of time my put me at risk for developing an addiction. This means that I could become preoccupied with taking my opioid medications and other prescribed or illicit drugs to the point that other aspects of my life could suffer. I will notify me physician if this occurs.
14. I understand that abruptly stopping my medication can result in withdrawal symptoms. This could be a life threatening medical issue.
15. I understand it is my responsibility to protecy my medications. If my medications are lost, destroyed or stolen, I understand they will not be replaced before the prescription is due. This could cause withdrawal symptoms as listed in numbers 12, 13 and 14.
16. I will only use the following pharmacy for my opioid medication prescription(s):

17. Pharmacy Name: _____ Phone#: _____

17. If I want to change my pharmacy, I agree that I must inform the physicians at Spine, Sports & Industrial Rehabilitation/Spinal & Orthopaedic Associates in writing of this change to include the name and phone number of the pharmacy.
18. I have read the above agreement and understand it. I have asked and had my questions answered concerning the Agreement. I consent to the use of the OPIOID Management Contract as detailed above and understand the random drug screening process. I acknowledge that the purpose of this OPIOID Management Agreement is to protect my self from addiction or other misuse of drugs, and to provide the physicians at Spine, Sports & Industrial Rehabilitation/Spinal and Orthopaedic Associates with information and controls necessary to monitor my treatment and avoid me taking more appropriate or from taking medications that may counteract in interact in ways that are harmful to me.



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I understand that if I fail to follow any provisions of this OPIOD Management Agreement, or fail a random drug screen as set forth above, that I will be dismissed from Spine, sports & Industrial Rehabilitation/Spinal & Orthopaedic Associates practice, without any further review, and that I will need to seek the care of another provider.

This is a form you will be required to sign if you receive prescriptions from our office.

DENIOGRAPHICS

Date _____ Referring Dr. _____ Date of Birth _____ Age _____ Sex _____

Patient Name _____ Marital Status [] M [] S [] W [] D

Address _____

City _____ State _____ Zip _____

SS# _____ Home Phone _____ Work Phone _____

Patient Employer _____

Employer Address _____

Responsible Party (if other than patient) _____ Relationship to patient _____

Date of Birth _____ Address (if different from patient) _____

SS# _____ Home Phone _____ Work Phone _____

In case of emergency, who should we notify?

Name _____ Phone # _____ Relationship _____

Primary Insurance

Card Holder
Insurance
Address

Phone #
Policy #
Group #

Secondary Insurance

Card Holder
Insurance
Address

Phone #
Policy #
Group #

Is this injury due to a work related accident? [] Yes [] No

(If you answered yes, we do not take Workers Compensation claims)

Is this injury due to an automobile accident? [] Yes [] No

Date of Injury _____ Case # _____



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(If yes you will need either a letter of protection from your attorney or a waiver letter of protection from your insurance stating they will pay for your treatments)

Please note: Any charges not covered by insurance will be patient's responsibility.

I authorize the holder of medical or other information about me, to release to the Social Security Administration or its carriers, or to my private insurance carrier, and any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in a place of the original. I request payment of medical insurance either to myself or to the party who accepts assignment. I authorize Dr. Korby to bill all services and allow my insurance carrier to issue benefit payments directly to Dr. Korby. I understand that any services not covered by insurance are the responsibility of the patient and the responsible party.

I fully understand that some procedures may not be covered services by Medicare or private insurance and that I am responsible for payment of those services.

Signature of Patient

Date

Signature of Responsible Party

Date

Provider Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices:

I hereby acknowledge I have been provided a copy of the Provider Notice of Privacy Practices of Spine, Sports & Industrial Rehabilitation/Spinal & Orthopaedic Medicine Associates and have reviewed such policy;

Please sign and print your name and date on this acknowledgement form:

Signature of Patient or Personal Representative: _____

Print Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: