SOUTHWEST PAIN MANAGEMENT
Relief begins here.

NARCOTICS CONTRACT

Dr. Groysman and his staff understand that your pain is a significant hinderance to the quality of life you desire. In order to help you achieve your goals we may utilize oral narcotics or other medication supplements with treatment. Narcotics have a long history of safety when used in the proper manner. Addiction to narcotics may occur with continuous use over several weeks; therefore, we must weigh the risks versus the benefits of using these medications. Dr. Groysman will discuss these risks with you when they are prescribed and your pharmacist will also give you more information. It is important to take all medications as prescribed by Dr. Groysman. Taking more medication than prescribed can result in serious and life-threatening complications including but not limited to: **respiratory failure, cardiac arrhythmia, possible overdose and death**. ***As of September 11th, 2011, in the state of Texas "Doctor Shopping" is a felony and will be reported immediately.***

Listed below are the terms and conditions you are required to adhere to in order to be under the care of Integrative Pain and Spine (SPM). If any of these rules ae violated, Dr. Groysman reserves the right to dismiss you from his care.

- I agree to take my medication as prescribed. If my pain level increases such that I need to increase my dosage, I will call SPM and discuss this with a nurse or Dr. Groysman before taking any action. _____ **(Initial)**
- I allow any providers, Dr. Groysman or staff members under the direction of the provider to perform random pill counts on any medications prescribed by SPM. _____ **(Initial)**
- I will not request or accept pain medication from any other provider or facility unless in an emergency situation (ie: trauma or injury resulting in a hospital visit/admission). _____ **(Initial)**
- I will fill my prescriptions only at the pharmacy on file with SPM. _____ **(Initial)**
- I am aware that lost or stolen prescriptions will not be replaced without a police report. _____ **(Initial)**
- I am aware that it is my responsibility to keep track of when my prescriptions will run out. I understand that prescription refills can take up to **48 hours** to process and I will plan accordingly. _____ **(Initial)**
- I understand that if I run out of my medication early, it may not be refilled by SPM. I understand that even if SPM chooses to refill my medication, my pharmacy may not. _____ **(Initial)**
- I consent to random drug testing to be performed by SPM. I understand that any detection of illicit substances may result in immediate dismissal from care. _____ **(Initial)**
- I understand that any illegal or drug seeking activities will be immediately reported to the authorities. _____ **(Initial)**
- I understand that in accordance with the law, I will be unable to receive my medication without an in-office visit with Dr. Groysman. I understand that in accordance with the law, no narcotics can be filled across Texas state lines. _____ **(Initial)**
- I understand that I will no longer receive narcotics if one of the following occurs:
    1. Dr. Groysman feels that narcotics are not relieving my pain adequately. _____ **(Initial)**
    2. I develop side effects that ae concerning to Dr. Groysman. _____ **(Initial)**
    3. I give away, sell or abuse the narcotics prescribed. _____ **(Initial)**
    4. The Texas Department of Public Safety database indicates I have obtained narcotics from another provider or facility. _____ **(Initial)**

- I understand that my pain management care may also include non-narcotic treatment. I am aware that if I refuse or do not follow through with the recommended treatment plan including non-narcotic options, that my narcotic treatment may be terminated. _____ **(Initial)**
- If I feel I have become dependent on narcotics or begin taking more than prescribed, I will notify SPM immediately and seek rehabilitation treatment. _____ **(Initial)**

THIS CONTRACT WILL REMAIN IN EFFECT FOR THE DURATION OF MY CARE WITH SOUTHWEST PAIN MANAGEMENT.

Date **Signature** **Printed Name**