BUFFALO SPINE SURGERY

Center For Excellence in Spine Care Dr. Andrew Cappuccino

PATIENT CONSENT FORM FOR OPIOID USE AND EXPLANATION OF BENEFITS

I,______________________________agree to the following conditions regarding opioid use:

I understand that I have a chronic pain problem that requires the prescription of an opioid pain medication for pain relief and to improve my functional ability. I am aware that the risks include, but are not limited to, drug dependency, addiction, respiratory depression, cardiovascular depression, liver and/or kidney damage, and even death. The physician has discussed the risks, benefits, and treatment alternatives with me prior to treatment.
X_______________(patient initials)

I agree that any prescription(s) I obtain for opioid(s) and other controlled medication(s) will be from this physician.
X_______________(patient initials)

I agree that I will disclose any other health care provider I am seeing, regardless of the reason.
X_______________(patient initials)

I agree my physician has my permission to contact other physicians and pharmacies to confirm compliance.
X_______________(patient initials)

I agree to have my prescriptions filled at only one pharmacy, and will notify my treating physician of the name and phone number of the pharmacy.
X_______________(patient initials)

I agree to take medication(s) only as prescribed and will notify my physician if I do not.
X_______________(patient initials)

I agree to random drug screens as directed by my physician.
X_______________(patient initials)

I agree to keep all scheduled appointments with my physician.
X_______________(patient initials)

I understand that lost, stolen, or misplaced controlled medications or their prescriptions WILL **NOT BE REPLACED**.
X_______________(patient initials)

I understand that refills will not be given early for any reason.
X_______________(patient initials)

I understand that refills will only be given during regular office hours.
X_______________(patient initials)

I will disclose any over-the–counter medications I am taking.
X_______________(patient initials)

I certify that I am not using any illegal, or non prescribed drug(s), and that I understand I will not be treated if I am.
X_______________(patient initials)

I understand that if my physician suspects drug addiction I can be referred for a psychological evaluation or drug treatment program.
X_______________(patient initials)

I understand that if I deviate from the above guidelines, treatment can be tapered off or discontinued, and that I may be discharge from the practice.
X_______________(patient initials)

_________________________________ _________________________ _______________________
Signature of Patient **Date of Birth** **Date**

_________________________________ _________________________ _______________________
Witness **Date**

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