Welcome to the practice of Dr. James Diede

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Expectations of Patients receiving Opioid Therapy

The Agreement between _____, Patient and Doctor is for the purpose of establishing agreement Doctor and Patient on clear conditions for the prescription and use of pain controlling medication prescribed by the Doctor for the Patient. Doctor and Patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor and Patient.

I understand that the goal of prescribing these medications are to increase my actives as home and /or work and decrease pain symptoms and behavior within the time specified in my treatment plan.

I understand Opioid medications are only one part of my treatment plan and agree to follow all parts of my treatment program. (E.g. physical therapy, behavioral pain management or injections)

I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there are any questions of impairment of my ability to safety perform any activity, I agree that I will not attempt to perform the activity.

I will not attempt to get pain medication from any other health care provider. If my primary care physician is willing to prescribe my medications, the doctor will make arrangements to transfer my care to my primary care physician.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

I understand that it is my responsibility to schedule and keep a follow-up appointment with my doctor for all medications refills. Medication will not be refilled over the phone or on a walk-in basis. Refills will not be made if you run out early.

Refills will not be made on an emergency basis. NO Opioid medication will be refilled over the phone or as a prescription without an appointment.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to provide the name and phone number of the pharmacy I will use. I will also use only one pharmacy to fill my Opioid medication.

I understand that failure to follow these guidelines may require stopping the Opioid and a referral to a substance abuse specialist and/or termination as a patient of Dr. Diede's.

CAUTION: Opioid medication may cause drowsiness. Alcohol SHOULD be avoided or used with extreme caution while taking medications. Use care when operation a care or machinery. Referral law prohibits the alteration of prescription or transfer of these drugs to any other person.

My signature below confirms that I understand and agree to all the above requirements to obtain Opioid and or sedative medications from Dr. Diede.

Patient Signature _____ Date _____

Copy given to patient, date _____