TAMPA INSTITUTE FOR
PAIN & SPINE

OPIOID AGREEMENT

I, _____ (Patient Name), agree to the following conditions:

1. I understand that I have a chronic pain problem that may require the prescription of opioid pain medication to increase my function. The risks, side effects, and benefits of the medication have been discussed with me in detail.

2. I understand that the use of the opioids in pain Management is an acceptable practice However, there is a potential for habit formation and in some instances may result in addiction.

3. I will obtain prescriptions for the opioids and other controlled medicines only from my Tampa Institute for Pain and Spine (TIPS) physician.

4. Prescriptions must be filled at one specific pharmacy one location and will provide TIPS of the name, phone number and fax number of my pharmacy. If for any reason I go to another pharmacy I understand I must call clinic immediately with information.

5. I will take the medications only as prescribed. Failure to do so may result in dismissal from our clinic. You must contact the clinic for an appointment to discuss any changes in your medication.

6. I understand the eventual goal of tapering the opioid medication.

7. I will meet regularly with my TIPS physician to assess my progress and may be required to have a follow-up visit prior to obtaining refills of medications.

8. Lost, misplaced, stolen or miscounted medication from pharmacies will not be replaced. Refills will not given early for any reason.

9. I will call TIPS at 813-513-TIPS (8477) to renew my medications and understand 48 hours notice is required to complete this request. No prescription will be filled or called in after business hours or on weekends.

10. I agree to random urine and blood tests to assess my compliance. The physician has the right to call you in at any time for random pill count/drug screen. Failure to comply may result in dismissal from our clinic.

11. I may not discard any prescribed medications. All medications must be returned to my TIPS physician.

12. I understand that the use of illicit drugs may represent grounds for dismissal from our clinic.

13. I understand that at every visit I will bring all prescription medications with me in their original containers on every appointment even if the bottle is empty. Failure may result in the rescheduling of my appointment.

14. Failure to comply with ordered procedures or test may result in the discontinuation of medications.

FAILURE TO COMPLY WITH THE ABOVE TERMS OF THIS AGREEMENT MAY RESULT IN DISMISSAL FROM TAMPA INSTITUTE FOR PAIN AND SPINE.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Pharmacy: _____ Phone: _____ Fax: _____

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