SILVER STATE NEUROLOGY

2575 Montessouri St., Suite 110
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NARCOTIC AGREEMENT

This is an agreement between _____, (me, the patient) and Silver State Neurology (my providers). It explains how I receive my medications (pain medication, narcotics, muscle relaxers, sleeping medications or other controlled drugs prescribed). I agree to take my medication responsibly and to follow all orders.

1. I agree to use the following pharmacy only:

   Name:_____ Location:_____.

2. I will attend all of my office visits. I will come in immediately, if asked.
3. I will not go to the ER or to other providers for these or similar medications.
4. I will bring my medication bottles to my appointment if instructed to do so.
5. I am personally responsible for my medications. I will treat them as my other valuables. I understand that they will not be replaced if lost, stolen, or destroyed.
6. I will not give my medication(s) to anyone else or take anyone else's medication(s).
7. I will not request early refills or take more than the prescribed amount.
8. For safety reasons, refill requests will only be honored at the time of my appointments.
9. I will inform my doctor of any new medications or medical conditions.
10. I agree to allow Silver State Neurology to perform urine tests needed to make sure I use my medications correctly.
11. I will not operate a car or other equipment when I use my medications unless expressly approved to do so.
12. It is my responsibility to comply with applicable laws while taking these medications.
13. I will not use alcohol or illegal drugs when using these medications.
14. I understand that there can be side effects from these medicines, including sedation, itching, nausea, vomiting, difficulty urinating, constipation, and other problems.
15. I understand that these medications could cause dependency.
16. I understand that suddenly stopping these medications may be dangerous.
17. If I violate these conditions, my providers may not refill the medications and may require that I obtain help to decrease my use of these medications.
18. I know that violating these conditions may result in my dismissal from the practice with no more than 30 days notice.
19. I further agree that my pain medication or other prescriptions may be stopped or decreased at any time, for any reason, by my providers.
20. I will be completely honest, about my use of these and all other medications. I will ask questions if I do not understand something or if I feel that I may be having trouble with the medication.

Finally, I understand that the above is not a complete list. I will be careful and will exercise caution and common sense.

_____ _____
Patient Name Date

_____ _____
Patient Signature Witness

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Dear Patient,

To comply with federal regulations of reporting controlled medications, and to determine if medications are interfering with our plan of care, Silver State Neurology is implementing urine drug screening **effective immediately**. All new and existing patients whom are prescribed any narcotic medications will submit to an immediate urine drug test screening.

If you have complaints that your current prescription(s) are no longer effective, we will ask you to submit a urine sample to ensure the medication is metabolizing correctly in your system before changing the prescription(s). By signing this form, you as a patient promise to take the prescription drugs prescribed by Silver State Neurology only as directed, not seek early refills or replacements for lost or stolen medications, not use illegal drugs and agree to quarterly drug screening.

I_____, understand that Silver State Neurology may
(Print Name)
stop prescribing medications if my behavior is inconsistent with the responsibilities outlined above, which may result in being prevented from receiving further care from this clinic.

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

We appreciate your understanding and cooperation to federal mandated compliance.