I, _____, agree to use _____ Pharmacy, located at _____ with telephone number _____ for filling prescriptions for all my pain medication. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state of Florida Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

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

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been provided to me upon my request.

I understand that, if I violate any of the above conditions, my provider may choose to stop writing opioids prescribed for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals.

I understand that, if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate for the institution.

Medication refill information:

1. Advance notice of 5-7 business days is required for all nonnarcotic prescription refills.
2. Requests for nonnarcotic scheduled refills must be telephoned to the pharmacy only during office hours (Monday - Friday 9:30am - 4:00pm). Refills will not be made at night, on holidays, or on weekends.
3. Most controlled substances cannot be telephoned in to the pharmacy.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me upon my request.

This agreement in entered into on (date) ____/____/20___.

Patient/Guardian signature: _____
Physician signature: _____
Witnessed by: _____