ROCKY MOUNTAIN
NEUROSURGERY

Medication Contract

The purpose of this agreement is to clarify how opioids are prescribed by the Physician, or the Physician's representative, to Rocky Mountain Neurosurgery patients.

Our Policy

- We are not required to provide opioid prescriptions. RMN does not provide pain management, but rather uses opioid medication in conjunction with planning and performing surgery. RMN reserves the right to deny requests for these medications.
- The Physician may decide to prescribe opioid medication to you prior to surgery planning, and/or in conjunction with ongoing non-operative therapy for a period not to exceed 45 days.
- Opioid prescriptions may be provided **post surgery** for a maximum of 45 days.
- You must have an appointment in order to obtain any opioid prescriptions under the guidelines mentioned above.
- After 45 days, alternative sources shall be recommended by the Physician which may include: return to primary care physician, a referral to a pain management program, or other treating physician.
- RMN will not write new prescriptions if you are enrolled in a pain management program.
- You must allow **48 hours** for processing of refills for non-opioid or non-benzodiazepine medications.

As a patient, I agree to comply with the following conditions:

- I understand if I break this agreement, my Physician will stop prescribing any medication.
- I will not use any illegal substance, including cocaine, methamphetamine, etc. while under this agreement and in the care of Rocky Mountain Neurosurgery.
- I will not trade with, borrow from, or give or sell any medications to anyone.
- I will not attempt to obtain any controlled medications, specifically narcotics, stimulants, or anti-anxiety medication from any other health care provider without written consent from my prescribing Physician.
- I will safeguard my medicine from loss of theft. **Lost or stolen medication WILL NOT be replaced.**
- I agree requests for prescription refills shall only be made during regular business hours. **NO REFILLS will be filled after hours, Fridays, or on weekends.**

I authorize the Physician, Physician's representative, and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including, but not limited to, the State Board of Pharmacy, the Board of Medical Examiners, and the Drug Enforcement agency (DEA) in the investigation of any possible misuse, sale, or other diversion of my medication. I agree to waive any applicable right to privacy or confidentiality with respect to these authorizations. I agree to comply with this policy. All my questions and concerns regarding this agreement have been answered. I can request a copy of this agreement.

Signature _____ Date _____/_____/_____

Print Name _____