OLYMPIA
ORTHOPAEDIC
ASSOCIATES PLLC
Your Life in Motion

Controlled Substance Policies and Contract

Please read and understand this document as you will be strictly held to the below guidelines.

If you do not sign this agreement, you will not receive opioid prescriptions. If you have signed this agreement and found to be in violation, your opioid medication may be tapered and/or discontinued.

Patient Name: ___________________________________ DOB: ________________ OOA Acct #: ___________________

We will provide opioid medication up to and **not beyond 6 weeks** postoperatively. Beyond this period, patients are responsible for obtaining medication from either their Primary Care Provider or a pain management provider. The goal is that you will not require opioid medication **beyond 6 weeks** postoperatively. Olympia Orthopaedic Associates (OOA) will not prescribe chronic pain medication for any reason on a long-term basis. Initials: ___________

Once filled, you are responsible for the safety and security of your prescription medication. We will not, under any circumstances write a new prescription for "replacement" medication, regardless of whether it has been lost, stolen, or used more quickly than prescribed. Initials: _________

Only your surgeon or their PA-C/ARNP can renew your prescription. **Opioid refills are not provided on weekends or after clinic hours.** You are responsible for notifying your provider **48 hours** prior to needing a refill. Please call the office at ____________________ Monday – Friday between 8am and 5pm for medication refills. Initials: __________

You agree to take the medication at the dose and frequency for which it has been prescribed by your surgeon. You also agree not to abuse alcohol or any other medically unauthorized substances. Initials: ________

Opioid medication is to be obtained only from your OOA provider. If an outside provider prescribes you opioid medication (i.e. from a hospital visit), you must notify OOA immediately. Initials: __________

You must identify and use only one pharmacy for this medication.

Pharmacy: ____ Location: _________________________

You accept the right of your OOA provider or other medical staff to terminate this agreement for any of the following reasons:

- You seek or obtain any opioid medication from a source other than your OOA treating physician or staff.
- You give, sell, or in any way distribute prescribed medication to any other person(s).
- You attempt to forge or alter a prescription in any way.
- Your medical condition declines to a point at which, in the judgement of your provider, continued therapy with opioid medication presents a danger to your well-being or safety.

I understand and agree to the terms of this contract. I also understand that if I am not compliant, I can be discharged from OOA at my provider's discretion.

Patient Signature: ____ Date: _________________________

OOA Provider: ____