Patient Name: _____ Date of Birth:_____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS POST OPERATIVELY

I understand Dr. Terrence Crowder may prescribe pain medication to assist me in managing my pain post operatively only. I agree to the following conditions of treatment:

1. Dr. Crowder will only prescribe pain medication 2 weeks post operatively. Any additional refills must be prescribed by primary care physician or pain management physician.
2. If you currently do not have a primary care physician or pain management physician please inform Dr. Crowder's team at your visit, so we are able to refer you to a physician in a timely manner.
3. I understand that I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my clinician's approval. I will contact Dr. Crowder or my pharmacy if I have any reactions to the medication.
4. I understand that I will give Dr Crowder's team 3 days notice for refills and no refills will be completed on Fridays.
5. I understand that lost or stolen prescriptions will not be replaced.
6. I understand that any disrespectful behavior, cursing, yelling, or inappropriate behavior will not be tolerated and I will be discharged from the practice immediately.

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by this agreement will result in the termination of medication prescriptions and the termination from Dr. Crowder and his practice.

Patient Signature:_____ Date: _____