Neurosurgical and Spine Specialists, PC

Consent Form for the use of pain control with Opioid medications

This is an agreement between_____ (patient) and Neurosurgical and Spine Specialists/Dr. Sean Markey concerning the use of opioid analgesics (narcotic pain-killers) prescribed.

- I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
- I agree that the opioids will be prescribed by only one physician. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with NSS/Dr. Sean Markey. I give permission for the physician to verify that I am not seeing other physicians for opioid medications.
- I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy while under the influence of opioid medication.
- I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
- I agree not to sell, lend, or in any way give my medication to any other person.
- I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication.
- I understand that NSS/Dr. Sean Markey will not provide long term pain management.
- I understand that if I am pregnant or become pregnant while taking these opioid medications, my child could be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
- NSS/Dr. Sean Markey is not responsible for any actions you take while under the influence of opioid medication.
- I agree to take my medication as prescribed by the physician and will not alter the dose on my own.
- If there is any evidence of drug hoarding, acquisition of drugs from other physicians, uncontrolled dose escalation or other aberrant behavior, this would be followed by tapering and discontinuation of opioid maintenance therapy.
- I understand no prescriptions will be refilled on Fridays, Saturdays, Sundays or Holidays.
- I understand NSS/Dr. Markey requires 72 business hours to process prescription renewal requests and/or pick-up requests.
- I understand I am responsible for knowing when medication(s) will need to be refilled.
- I understand Prescriptions will not be filled for unauthorized "walk in" patients.

Signature of Patient or Guardian: _____ Date: _____

Physician Signature: _____