Jagannathan Neurosurgical Institute PLLC

30755 Stephenson Highway

Madison Heights, MI 48071

Patient Agreement & Informed Consent for Opioid Therapy

I, the patient signed below, understand that my providers at Jagannathan Neurosurgical Institute may initiate narcotic medication management. I have been informed and clearly understand the following issues regarding the treatment of pain with these medications, as well as other analgesic and sedative medications and I am fully aware that failure to abide by any of these conditions will be considered a breach of contract and may result in the termination of the patient- physician relationship.

1. **Sole providers:** The physicians at Jagannathan Neurosurgical Institute .will be the only providers to write narcotic prescriptions for a period of 12 weeks (3 months following surgical procedures). **I will not obtain or accept** prescriptions for narcotic medications (related to my neurosurgical issues) from any physicians outside of this professional group during this period. Nor will I take medications prescribed to someone else or allow someone else to take medications prescribed to me. Prior to surgery, and after 12 weeks, my narcotic pain medication management will be managed by my primary physician or pain specialist.
2. **SafeKeeping:** I understand that I am responsible for the safekeeping of my prescriptions and medications. If I should lose them or if they are stolen, I will not be given replacements and I could experience the symptoms of withdrawal.
3. **Pharmacy:** I agree to use only one pharmacy in my town of residence.
4. **Medication Dosages:** I understand that my physician will prescribe my medications in dosages the he/she deems necessary. **I will not adjust the amount of medications I take without first contacting**

the prescribing physician. If I should adjust the medication I am taking, and run out early, I will **not** be given additional medications to "get me through" until my next scheduled appointment. I understand that increasing my dose without medical supervision could lead to drug overdose, causing severe sedation, respiratory depression, cardiac arrest and death.

5. **Side Effects:** I am to notify my provider of any adverse effects that I might experience while taking narcotic medications. Adverse effect include but are not limited to: over- sedations, nausea, vomiting, constipation, euphoria, dysphoria, dizziness, sweating, itching, rashes, swelling, difficulty breathing, dysuria, dry mouth, insomnia, disorientation, decreased sex drive and potency and abnormal jerking motions in the arms and legs. While on narcotic medications, I will not operate a ***motor vehicle*** of any type or any other form of machinery that could cause injury to others or myself.
6. **Physical Dependence:** It is clearly understood that the use of these medications may result in physical dependence.
   Page1/2 Opioid Therapy
7. **Psychological Addiction:** I understand that psychological addiction is a possible risk associated with these medications. If I exhibit such behavior, I will be tapered off my medications and will no longer be considered a candidate for narcotic therapy. Recognized addictive behaviors include but are not limited to: abuse of the drug to obtain mental numbness or euphoria, drug craving behavior, "doctor shopping", escalating drug usage without correlation with pain relief, and manipulative behavior toward the medical provider in order to obtain prescriptions.
8. **Other Drugs:** I will not use alcohol or other recreational drugs while on narcotic medication as this could cause profound sedation, respiratory depression, low blood pressure and death.
9. **Pregnancy:** If I am female, I agree to advise my physicians if there is any chance that I am or may become pregnant. I understand that infants born to mothers on narcotics will likely be dependent at birth and could possibly have birth defects as a result of the medications.

10. **Release of Information:** I agree to allow my physicians contact with other providers, emergency departments, pharmacies and urgent care facilities regarding information related to this agreement. I further allow these outside entities to disclose to my physicians any information required to ensure my adherence to this agreement.
11. **Severability:** I understand that if any provision of this agreement is determined to be invalid or unenforceable, then the remainder of the agreement will remain in force.
12. **Termination:** I understand that either party upon 30 days written notice to the other may terminate this agreement. Delivery of such notice by US postal service certified mail to my address of record shall be deemed sufficient notice. It is the patient's responsibility to ensure that Jagannathan Neurosurgical Institute has a current and legitimate address on file.

I have read the above information (or it has been read to me) and all of my relevant questions have been answered to my satisfaction.

_____
Patient's printed name

_____
Patient's signature

_____
Date Signed