



River City Orthopaedic Surgeons, PSC
9300 Stonestreet Rd., Suite 200
Louisville, KY 40272
(502) 935-8061

PRESCRIPTION MEDICINE AGREEMENT

The purpose of this agreement is to prevent misunderstandings about prescription medicines you will be taking for pain control while being treated by this medical practice. This is to help both you and River City Orthopaedic Surgeons, PSC to comply with the law regarding prescriptions and controlled medicines.

I understand that this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement.

I further understand that if I break this agreement, my doctor will stop prescribing prescription pain control medicines for me. If I break this agreement my doctor will have the right to discontinue the prescription of pain control medications and reserves the right to refuse prescribing pain control medications in the future. As well as, the right to refuse to see me as a patient.

I will honestly and fully communicate to my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how the medicine is helping to relieve the pain.

I will not illegally use any controlled substances, including marijuana, cocaine, heroine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled prescription medications including opium or opium-based medicines, controlled stimulants, or anti-anxiety medicines with any other doctor while receiving and ingesting pain medicines from River City Orthopaedic Surgeons, PSC physicians.

I will safeguard my pain medication from loss or theft. Lost or stolen medicines I understand will not be replaced until the appropriate time as directed by the schedule associated with my prescription.

I agree that refills for my prescriptions for pain medicine will be made only during office hours. I understand that no refills will be available during evenings, weekends, or on holidays.

I further authorize River City Orthopaedic Surgeons, PSC and its member physicians as well as my pharmacy to cooperate fully with any state, city or federal law enforcement agency including Kentucky's Board of Pharmacy in the investigation of any possible misuse, sale or diversion of my pain medicines prescribed by River City Orthopaedic Surgeons, PSC. I authorize River City Orthopaedic Surgeons, PSC and its member physicians to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privileges or right of privacy of confidentiality with respect to these authorizations.

I agree I will use my pain medication at a rate no greater than the prescribed rate that my physician and River City Orthopaedic Surgeons, PSC directs, and that use of my medicine at a greater rate will result in my being without medication for a period of time until it can be refilled according to the directives by River City Orthopaedic Surgeons, PSC and its member physicians.

I agree that these guidelines stated above have been fully explained to me or I have read the document and completely understand it's meaning, and that all my questions and concerns regarding treatment associated with pain medication have been answered adequately.

I further acknowledge that a copy of this agreement was offered to me and if I do not have it, this is because of my choice, but I understand a permanent copy will be on record at the offices of River City Orthopaedic Surgeons, PSC.

Patient Signature: _____

Witnessed by: _____

Date of Agreement: _____