ACTION PHYSICAL MEDICINE & REHABILITATION

Phone: (815) 725-4918
Fax: (779) 803-3278
1890 Silver Cross Blvd., Pavilion A, Suite 425
New Lenox, IL 60451

Phone: (630) 904-5640
Fax: (630) 470-9298
1315 Macom Drive, Suite 005
Naperville, IL 60564

MEDICATION AGREEMENT

Patient's Name: _____ Date: _____
Doctor's Name: J. Mikuzis D.O. / N. Georgelos D.O.

I understand that this Agreement is essential to the trust and confidence necessary in a physician and nurse/patient relationship and will treat me based on this Agreement. Additionally, this agreement will help to prevent misunderstandings about certain medications, especially opiates; I may be taking for pain management. Not all patients are placed on these medications, however all patients are required to sign this agreement as part of their relationship with this medical practice. This is to help both the patient and the physician/nurse to comply with the law regarding controlled pharmaceuticals. It is also an explanation of some of your responsibilities concerning our medical practice and some of the medical practice's responsibilities towards our patients.

I specifically agree:

1. I will not use any illegal controlled substance. If I am using marijuana for medical purposes, I will provide a copy of my Illinois Department of Public Health Medical Cannabis Registered Qualifying Patient Card. Further I will disclose any past use of illicit medications, substance dependency or addiction treatments or current use of illicit substances. I will disclose any alcohol usage, addiction or alcohol dependency treatment past or present, to my physician or nurse. Withholding this information places me at risk for continued destructive behavior and potential serious side effects from some of the medications that might be used in your care. If asked to see a substance dependency counselor by my physician I will carry out this request.
2. I will not share, sell, or trade any of my pain medication to anyone. I will not use any pain medications offered to me by friends, acquaintances or family members. Prescription alteration, seeing multiple physicians for scheduled medications, inappropriate administration of medications and/or selling pain medications is a felony and will be reported to the appropriate authorities and I will be discharged from Action PM&R.
3. I will not attempt to obtain controlled medicines, including opioid pain medicines, neuro-stimulants, or anti-anxiety (unless prescribed by a psychiatrist) medicines from any other physician or physician assistant. If I have a medical emergency that requires me to go to an Emergency Room or be hospitalized, and I am prescribed narcotics and/or other controlled substance medications, I will call Action PM&R the next business day, or at the earliest possible opportunity, and inform them of such prescriptions, and I will bring in a discharge summary/documentation (e.g. prescription bottles, etc.) of such medications.
4. It is important that I communicate the names of all the physicians, physician assistant, chiropractors or other health care professionals to my physician (including mental health care professionals) whom I see on a regular basis. It is critical, for quality patient and good coordinated care, we communicate with these health care providers. Further you should have a primary care provider to provide you with regular medical care.

Initial_____

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5. I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. To reduce the instance of medications loss/theft, carry only the amount of medication with you that you will be using when away from home. Given the recent publicity regarding opiate abuse, I will keep confidential the type of medications I am taking.
6. Due to recent DEA policy changes we must see patients who are on controlled opiate or other scheduled medications on a monthly basis.
7. I agree that refills of my prescriptions for pain medicines will be made at the time of an office visit and during office hours. No refills will be available after hours, on weekends or holidays. This will be the date by which we base our prescriptions and will give me a month's worth of my medication. I will only use one pharmacy for all my opiate prescriptions. I list the name of that pharmacy in the space provided below.

   Pharmacy name: _____

   Address: _____

   Phone: _____ Fax: _____

8. I understand that before my doctor will renew my prescriptions, I must keep all my scheduled appointments and contact my doctor at agreed upon times to let him/her know how my medication is working
9. If requested, I will return all medications that were not effective in my care. I will return them as requested so they may be disposed of appropriately.
10. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of medicine at a greater rate will result in my being without medication for a period of time, or I could be terminated from Action PM&R. I will use the medication as indicated and not break, crush or use medications prescribed in ways not appropriate.
11. I agree that I will submit to a blood or urine test, if requested by my doctor or nurse to determine my compliance with my program of pain control medicine. Additionally, I may be asked to present myself to Action PM&R with all my medications for a pill count and will comply within the time frame required.
12. Inappropriate behavior or language towards any of the staff of Action PM&R, in person or on the phone, will result in my discharge from the practice. Action PM&R realizes that chronic pain can cause a patient to be less than pleasant. Action PM&R believes that all persons should be treated with respect and kindness and will do our best to always treat you with the respect you deserve.

Patient's Name: _____

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13. For Women: I will do everything I can to avoid getting pregnant while taking opioid analgesics and /or other controlled substance medications. To the best of my knowledge, I am not pregnant now. If I get pregnant while on medications, I will inform Action PM&R immediately.
14. I am aware of the common side effects associated with opioid and/or other controlled substance medications listed here: Constipation, nausea, difficulty concentrating, dizziness, problems with coordination or balance, increased sleepiness and/or drowsiness, itching, tolerance and withdrawal. (Withdrawal: Which means that abrupt stopping of the medication may lead to the following symptoms: runny nose, diarrhea, abdominal cramping, "goose flesh", anxiety, sweating etc.)
15. I also understand that Narcotics and other Scheduled substances are addictive, and may have side effects that can be hazardous, especially in high doses. These medications are being prescribed to me, by my physician, in good faith, and because indicated for my condition. I will hold Action PM&R and its Physicians and Staff blameless for any effects that may occur as a result of the use of these drugs, including, but not limited to addiction, tolerance and altered mental status. The decision to use these medications has been with my informed consent and is in accordance to my wishes.
16. I understand that if I break this Agreement, Action PM&R will stop prescribing medicines, and will terminate my care. In the event of termination, Action PM&R will treat my withdrawal symptoms, if any, for up to 30 days. Also, a drug dependence treatment program may be recommended

I agree to follow these guidelines that have been fully explained to me by

_____. All of my questions and concerns regarding this Agreement have been adequately answered. A copy of this Agreement has been given to me, a signed copy will be placed in my medical record and a copy may be provided to my pharmacy.

This Agreement is signed this _____ day of _____, 20_____.

Patient's signature: _____

Action PM&R Signature: _____

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PRESCRIPTION POLICY AGREEMENT

Patient's Name: _____ Date: _____
Doctor's Name: J. Mikuzis D.O. / N. Georgelos D.O.

The purpose of this policy is to ensure all prescription re-fills requested are responded to in a timely fashion.
You may do so by calling your pharmacy and having them fax over the request for the correct medication that is needed.
When properly staffed, our policy is to have all medications re-filled within 5 business days from the time of the request.
In order to help facilitate filling prescription refills a **five business day notice is required** for all prescription refills

Action PM & R has made an administrative decision to charge a $10.00 fee for prescription refills when the following conditions apply:

- All prescription refill requests that are made by phone to our office or in person outside of an appointment time.
- When the patient requires immediate attention pertaining to their prescription request, due to not following the prescription policy of 5 business days to be reviewed.
- When the patient is requesting a dosage change outside of a scheduled appointment.
- When a patient has an expired, lost, or stolen prescription that needs to be re-written.
- When the patient fails to order all prescriptions needed in the same request (i.e. requesting refills on different medications within the same week).

The following administrative charges may also apply in the following situations:

- When the patient makes requests that take time that is above and beyond the normal amount of time typically allotted for that task (ex. pre-authorization letters for medications, medication samples that are not in stock, etc.)

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding this Agreement have been adequately answered. A copy of this Agreement has been given to me, a signed copy will be placed in my medical record and a copy may be provided to my pharmacy.

This Agreement is signed this _____ day of _____, 20_____.

Patient's signature: _____

Action PM&R Signature: _____