Midwest Sports and Pain Specialists, P.C.
Narayan (Bob) S. Tata MD
(Board Certified in Physical Medicine and Rehabilitation & Pain Management)
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NARCOTIC AGREEMENT

Prior to receiving any controlled substances from our practice, you must be aware of the risks, benefits, and other potential options available to you. You must read and agree to abide to the following:

- I understand that controlled substances may be addictive. My physician has explained the risks, benefits, and alternatives to the use of controlled substances.
- Telephone calls-No prescriptions will be refilled after regular business hours. Regular business hours are Monday thru Friday 9:00 am to 4:00 pm.
- Please allow 24-48 hours for medication refills to be taken care of.
- Lost/Stolen medications or prescriptions will not be replaced unless a police report has been filed and a copy has been provided to the practice.
- Driving or operating heavy machinery is strictly prohibited while taking controlled substances.
- Random drug screening-As part of this agreement, you consent to random urine or blood screening. This is done in order to ensure that you are using the medication appropriately as well as to rule out the use of illegal substances.
- I agree not to obtain any controlled substance from any other physicians and or other sources.
- Pregnancy/Lactation-I am currently not pregnant nor do I intend to become pregnant. Should I become pregnant or choose to try to become pregnant, I will immediately notify my physician. Use of controlled substances while pregnant may cause fetal abnormalities.
- Use of alcohol is prohibited while taking controlled substances.
- I agree to use only one pharmacy. It is my responsibility to notify the physician if I choose to change my pharmacy.
- Follow-Up visits-I understand that periodic visits will be required for the purpose of determining the effectiveness of my treatment and my compliance with the above contract.

I understand that should my physician feel that I have violated any of the terms of the above contract, my physician will terminate the prescribing relationship.

(Signature of Patient) **(Date)**

(Print Name)