Spine & Orthopedic Center of N.J., LLC.

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PAIN MANAGEMENT CONTRACT

The purpose of this contract is to prevent misunderstandings regarding specific medications you may need for pain management and/or drug abuse. This contract is to help you and Dr. Basch to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this contract, **Dr. Basch will stop prescribing medication immediately**. In this case, Dr. Basch will taper off my medication, as necessary, to avoid withdrawal symptoms.

I agree that Dr. Basch will be the only physician prescribing particular medications for me. **I will not attempt** to obtain any controlled medication(s), such as **Percocet, Oxycontin, Vicodin, Lortab, Tylenol with Codeine, Darvocet, Duragesic Patches, Methadone, Suboxone, etc.** brand or generic) from any other physician, hospital etc.

I agree to use only one pharmacy to fill my medications. I agree to give the name and phone number of my pharmacy to Dr. Basch:

PHARMACY:_____**//**_____**PH#:**_____
NAME **TOWN**

I will not use any illegal substances; including Marijuana, Cocaine, Heroin or Alcohol. **I will not** share, sell or trade my medication with anyone. **I will** safeguard my medication from loss or theft. **I am responsible** for taking my medication as prescribed. **Lost, stolen, or misplaced medications will not be refilled and medications will not be filled early under any circumstances.**

Refills of medication will only be filled at an office visit and/or on the prescription line. A 48 hour notice will be given if called into the prescription line. Any changes in my medication will require an office visit with Dr. Basch.

No refills will be requested on evenings, weekends or holidays. Refills left with the answering service or on personal voice mails will not be honored.

I authorize Dr. Basch and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the State Board of Pharmacy, in the investigation of any possible misuse or sale of my medication**. I authorize Dr. Basch** to provide a copy of this contract to my pharmacy and/or insurance company. **I agree** to waive any applicable privilege, right or privacy, or confidentiality with respect to these authorizations.

Patient name:_____ _____ Date:_____
SIGNATURE **PRINT**

Witness:_____ _____ Date:_____
SIGNATURE **PRINT**