If other treatments have not worked to control your pain, David A. Gentile, DO, ABAARM, ABIHM may need to prescribe you long-term medications to help manage your pain and to improve the quality of your life. You must adhere to several conditions in order to have Dr. David Gentile manage this type of treatment for you.

Please initial each rule as read, below:

1. _____ I agree to obtain all prescriptions for controlled substances from Dr. Gentile only and to take only those medications as prescribed by Dr. Gentile.

2. _____ I agree to keep all scheduled appointments regarding my chronic pain. I understand that monthly visits are required.

3. _____ I agree to allow Dr. Gentile to communicate with other physicians and any pharmacists regarding pain management as deemed necessary.

4. _____ I understand the possible adverse effects and dependencies associated with controlled substances as discussed with Dr. Gentile.

5. _____ I agree to perform drug screening tests and quarterly routine labs to evaluate kidney function, including blood alcohol levels, when Dr. Gentile requests it.

6. _____ I agree to contact Dr. Gentile at (631) 821-4200 within 24 hours if an unavoidable emergency occurs requiring an ER visit, or an inpatient admission.

7. _____ I agree to call 5 business days in advance for regular refills of medication. Controlled substances will NOT be mailed under ANY circumstances.

8. _____ I agree to use only one pharmacy, ____________________________, Phone #(___)________________, for filling my prescriptions for controlled substances.

9. _____ I will not use illegal substances, street drugs or abuse alcohol while taking controlled medications. I will not take controlled substances prescribed for other people.
10._______I will not be involved in the sale, illegal possession, diversion, or transport of controlled substances like narcotics, sleeping pills, or nerve pills.

11._______Females Only: I certify that I am not pregnant. I certify that I will use appropriate measures to prevent pregnancy during the course of my treatment with controlled substances.

12._______I understand that NO allowances will be made for lost prescriptions, drugs, or any problems I may have with transportation or dates of pick up.

13._______I understand this mode of treatment will be terminated if any of the following occurs:
   • I give away, sell, or misuse my prescribed drugs.
   • I use other peoples’ drugs or illegal substances.
   • I am noncompliant with any of the terms of this agreement.
   • I disrespect or harass any personnel in regard to my prescriptions.
   • I do not follow up regularly or as requested by my physician.

14._______I agree to have ______________________________________ as a designated person to pick up my narcotic prescription in the event that I am unable. I will notify my pharmacy.

15. Exceptions to the above include:

________________________________________________________________________

I have read this agreement, understand it, and have had all questions answered satisfactorily. I consent to the use of controlled substances under the terms outlined in this agreement.

______________________________________________  __________________
Patient Signature                         Date

______________________________________________ __________________
Witness                         Date