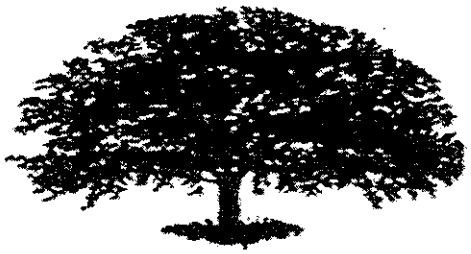

ADVANCED
GERIATRICS &
PRIMARY CARE, LLC

MEGUMI MAGUCHI, MD

Quality care for a better quality of life.

NARCOTIC AGREEMENT

By signing this agreement, I am stating that I understand the risks and benefits of this class of medications as well as the policies of this practice regarding its use and agree to abide by these policies.

- I understand 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 will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.
- I agree to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines only from the physician listed below, unless I am already being prescribed pain medications by another physician. Additional physician prescribing narcotics. _____
- I will not use any illegal controlled substances such as marijuana and cocaine. I will not share, sell or trade my medications with anyone.
- I agree that I will use my medicine at a rate no greater that the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. If requested by my doctor, I will bring all unused pain medicine to every office visit.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written or filled will not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.
- I authorize my doctor to provide a copy of the agreement to other providers, emergency departments and pharmacies and allow pharmacies to release my prescription history. I also consent for other providers, emergency departments or pharmacies to report violations of this agreement to the prescribing provider(s).
- I authorize my doctor and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the State of Florida's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient Name: _____ DOB: _____/_____/_____

Patient Signature: _____ Date _____/_____/_____

Physician Name: Dr. Megumi Maguchi Physician Signature_____