PRESCRIPTION MONITORING PROGRAM

ORTHOPAEDIC ASSOCIATES OF CENTRAL TEXAS

AUSTIN BONE & JOINT CLINIC

GAO GREATER AUSTIN ORTHOPAEDICS

Please initial in acceptance of the following points:

_____ I understand that OACT/ABJ has instituted a prescription drug monitoring program Designed to protect the patient, the community and the physician in the instance in which a narcotic pain medication is or will be prescribed

_____ I understand that in certain situation I may be tested in order to receive prescription narcotic medication.

_____ I understand that results of my screening are utilized only to determine the ability of the physician to prescribe dangerous narcotics medication and may not be disclosed to anyone I have not provided authorization to receive that information.

_____ I understand that this information is part of my medical records.

_____ I understand that if I refuse to participate in the prescription screening program that the physician may not prescribe narcotic pain medication but prescription alternatives.

_____

Patient Name

_____

Signature

_____

Date