US MEDICAL PLAZA
232 MERRICK RD, LYNBROOK NY 11563
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(516) 256-5556-FAX

EXPRESS MEDICAL CARE
357 BROADWAY, AMITYVILLE NY 11701
(631) 789-7900
(631) 608-8492-FAX

COMPLIANCE CONTRACT

It is our goal at Dr. Ahmed Elkoulily's office to take a multidisciplinary approach when treating chronic pain or opioid addiction. We aim to treat the mind and the body using multiple therapies and agencies. Therefore, we will likely be referring you out to physical therapy and/or psychological services. Upon referral we ask that you seek the first available appointment with these providers. Since these therapies play a very important role in your treatment program, attendance will be monitored.

Please note that appointments are at a premium with Dr. Ahmed Elkoulily M.D.P.C and these outside providers. Therefore we ask that you give us **24 hour notice should you need to cancel or reschedule.** A total of three successive **no shows** with **any** provider will prompt a re-evaluation of your commitment to this program and could possibly result in dismissal from the practice. **Exceptions may be made in extreme circumstances.**

Our office requires 5 business days to complete forms that will be filled out by a qualified staff member. Please note that a fee is charged for each form to be completed. However, there will be no charge for Government Disability forms. Please plan accordingly, as there are no exceptions.

Lastly, we at the office have adopted a **Zero Tolerance** policy with regard to abuse in the workplace. At no time will foul or abusive language or behavior directed towards our staff be tolerated. These actions are grounds for immediate dismissal from our practice.

Your signature indicates you understand this contract and agree to abide it.

Signature Date

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Patient Agreement/Informed Consent of Opioid Therapy / Opioid Addiction Therapy

I, _____, have consulted with my provider at Ahmed Elkoulily MDPC and we have agreed to try controlled substances as a part of the agreed upon treatment plan. I have been informed and clearly understand the following issues regarding the treatment plan with these medications, as well as other analgesic (pain relieving) or sedative medications. I am aware that failure to abide by any of these conditions will be considered a breach of this contract and may result in the termination of the patient-provider relationship.

1. **Monthly Appointments:** are required for prescription refills. Prescriptions will only be written during regularly scheduled appointments. If I cancel an appointment or miss one without calling, I understand that my prescription will not be refilled until I am seen in the clinic. I further understand that my medications to assist with the symptoms of withdrawal can be written at my provider's discretion.
    a. The *symptoms of withdrawal* may include: sweating, anxiety, tremors, muscle aches, hot and cold sweats, abdominal cramps and diarrhea, nausea and vomiting.
2. **Sole Providers:** The providers at Ahmed Elkoulily MDPC will be the only providers to write prescriptions for sedative medications and/or analgesics of any sort. **I will not accept prescriptions for these medications from any other provider outside of this practice.** Nor will I take medications prescribed for someone else or allow someone else to take medications prescribed to me.
3. **Safe Keeping:** I understand that I am responsible for the safe-keeping of my prescriptions and medications. If I lose them or they are stolen, I will not be given replacements and I could experience the symptoms of withdrawal.
4. **Pharmacy:** I agree to use only one pharmacy to fill my medications and to accept prescriptions for the generic form of my medications.
5. **Medication Dosage:** I understand that my provider will prescribe my medications in dosages that he/she deems necessary. **I will not adjust the amount of medication I take without first contacting Ahmed Elkoulily MDPC.** If I should adjust the amount of medication I am to be taking and I run out early, I will not be given additional medications to "get me through" until my next appointment. I understand that increasing my dose without close supervision could lead to drug overdose, causing severe sedation, respiratory depression and death.
6. **Side Effects:** I am to notify my provider of any adverse side effects that I might experience while taking analgesic, opiate blocker or sedative medications.
    a. Adverse side effects include: over-sedation, nausea, vomiting, constipation, confusion, euphoria (feeling "high), and dysphagia (feeling "low"). Other side effects include: dizziness, sweating, itching skin rashes, swelling, difficulty with urination, dry mouth, insomnia, disorientation, decrease sex drive and potency, and quick, sudden jerky movements of the arms and legs.
    b. **Motor Vehicles:** If my medications should cause me to feel drowsy, dizzy or disoriented, I agree to not operate a motor vehicle or other heavy machinery which could cause bodily injury to me or others.
7. **Treatment Goal:** I understand the treatment goal is to improve my ability to function and/or work. In consideration of that goal and that I am being given potent medication to help me achieve that goal, I agree to help myself by following better health habits (i.e. exercise, weight control and the cessation of alcohol and tobacco use) and by complying with the recommendations of my provider in the use of adjunctive therapies (i.e. physical therapy, psychological counseling). I further understand that if I refuse to participate in any adjunctive therapies, I will be tapered off of these medications and other methods of pain control will be explored.

8. **Physical Dependence:** It is clearly understood that the use of these medications may result in physical dependence. This condition is common to many drugs such as blood pressure medications, anti-anxiety medications and anti-seizure medications, as well as opioids.
9. **Psychological Addiction:** I understand that psychological addiction is a possible risk associated with opioid use. If I exhibit such behavior, I will be tapered off my medications and will no longer be considered a candidate for opioid therapy.
10. **Other Drugs:** I may not take other drugs such as tranquillizers, sedatives or antihistamines without first contacting Ahmed Elkoulily MDPC. I may not use alcoholic beverages or "recreational drugs." The combination of these drugs/ beverages and those medications prescribed by my provider could produce profound sedation, respiratory depression, severe drop in blood pressure and possibly death. I agree to submit to random urine drug/alcohol testing at the discretion of my provider.
11. **Pregnancy:** If I am a female, I agree to advise the clinic if there is even the slightest possibility that I am or may become pregnant. I understand that infants born to mothers on opioid therapy or opioid addiction therapy will likely be physically dependent at birth and could possibly have birth defects as a result of the medications.
12. **Release of Information:** I agree to allow Ahmed Elkoulily MDPC, to have contact with other providers, Emergency Departments, pharmacies and urgent care facilities regarding this agreement. I further allow these outside entities to disclose to Ahmed Elkoulily MDPC any information required to ensure my adherence to this agreement.
13. **Severability:** I understand that if any provision of this agreement is determined to be invalid or unenforceable, the reminder of the agreement will remain in force.
14. **Termination:** I understand that this agreement may be terminated by either party upon 30 days written notice to the other. Delivery of such notice by the US Postal Service Certified Mail to my address of record shall be deemed sufficient notice. It is my responsibility to ensure that Ahmed Elkoulily MDPC has my current valid address. I may notify Ahmed Elkoulily MDPC of my intent to terminate our relationship in a similar fashion. I must send my notice to any office of Ahmed Elkoulily MDPC.

I have read the above information (or it has been read to me), have asked for and received a copy of the agreement and all of my questions regarding my treatment with opioids or for opioid addiction have been answered to my satisfaction. I hereby give my consent to participate in the suggested treatment plan.

_____ _____

Patient's Printed Name Patient's Signature

_____

Date Signed

PRIMARY Pharmacy Name and Phone Number _____

_____