SPECIALISTS
IN PAIN CARE

today's date_____ Patient Name_____ date of birth_____

Patient Agreement for the use of Opioid Medications

The purpose of this agreement is to give you information about the medications that may be part of your treatment plan while in pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

Our Commitment

Specialists in Pain Care is making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

1) Specialists in Pain Care will make sure that your pain treatments will be as safe as possible.
2) Specialists in Pain Care will monitor your prescriptions and test for substance abuse to ensure you are taking your medications safely and correctly.
3) Specialists in Pain Care will recommend other forms of treatment, such as physical therapy, behavioral therapy, addiction counseling, and injection therapy, to help you with your pain condition and improve functioning.
4) Specialists in Pain Care will set treatment goals and monitor your progress in achieving those goals.

If you are prescribed opioid medications as part of your pain treatment plan, you will agree to following conditions:

(please check each box to indicate that you have read or have had the information explained to you)

☐ I agree that all medications for the control of my pain will be prescribed only by a Specialists in Pain Care physician/ medical provider. I will not request or accept opioid pain medication from any other source while I am receiving such medication from my physician/medical provider at Specialists in Pain Care.

☐ I understand that my first office visit may be a consultation only and no pain medication given at that time if further investigation and/ or testing is deemed necessary.

☐ I agree to use only one pharmacy for all of my pain prescriptions. If I change pharmacies for any reason, I agree to notify Specialists in Pain Care.

☐ I agree to participate in all other types of treatment that I am asked to participate in by my physician/medical provider at Specialists in Pain Care.

☐ I understand that my pain medications are prescribed for my use only. I will not share, trade, or sell my pain medications to anyone else.

☐ I agree to use my pain medications exactly as prescribed including the prescribed dose, time or frequency, and route.

☐ I agree to keep my pain medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

☐ I agree to provide Specialists in Pain Care with information regarding any and all medication I am taking for any medical condition. If another physician/ medical provider prescribes any new or additional medications, I agree to notify Specialists in Pain Care immediately.

☐ I agree to notify Specialists in Pain Care if I am prescribed any medicines that can be addictive, such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine).

☐ I understand that if a new condition develops that causes acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

☐ I agree not to use illegal drugs such as heroin, cocaine, marijuana, or amphetamines.

☐ I understand that the combination of controlled substances and alcohol are contraindicated; the combination may result in serious harm or even death.

☐ I agree to treat the staff at Specialists in Pain Care respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped. I understand that I (or any family member) may not loiter or smoke in the parking lot outside our facility.

MONITORING

☐ I understand that I must be re-evaluated on a regular basis by my physician/ medical provider at Specialists in Pain Care. I agree to come in for all evaluations ordered by my physician/ medical provider at Specialists in Pain Care. I understand that failure to schedule visits and/ or failure to keep my appointments result in Specialists in Pain Care's decision to stop providing further treatment to me.

☐ I agree to submit to blood, urine, or saliva testing, if requested by my physician/ medical provider at Specialists in Pain Care, to determine compliance with my pain treatment plan. If I fail to provide the sample when asked, I may forfeit the right to continue receiving the pain medication.

☐ I agree to periodic random drug screening and pill counts at the discretion of my Specialists in Pain Care physician/ medical provider. I understand that I may called at any time, and I will be given 24 hours to appear for that appointment. I understand that I must make sure the office has current contact information in order to reach me. If I fail to provide the sample when asked, I may forfeit the right to continue receiving the pain medication.

Appointments and Refills

☐ I understand that refills will be made only during regular office hours.

☐ I understand that Specialists in Pain Care will not provide early refills.

☐ I understand that there are no "walk-in" appointments for opioid medication refills.

☐ I understand that Specialists in Pain Care will not mail prescriptions.

☐ I understand that missing appointments or cancelling or rescheduling appointment with less than 24 hours advance notice may result in a discontinuation or reduction in my pain medication.

☐ I agree to follow through on appointments that may help me with my chronic pain and functioning. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery, neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of your opioid pain medications.

Tolerance, Dependence, Addiction

☐ I understand that some patients develop tolerance to pain medications (i.e., opioids). Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. If tolerance develops, my pain medication may have to be adjusted (increased or decreased) as deemed by the Specialists in Pain Care physician/ medical provider.

☐ I understand that some of the pain medications (i.e., opioids) prescribed for my condition are controlled substances, and there is a risk of physical and psychological dependence. If this happens, I will follow the treatment plan set forth by the Specialist in Pain Care physician/ medical provider.

☐ I understand that some of the pain medications (i.e., opioids) prescribed for my condition are controlled substances, and there is a risk of addiction. Addiction is defined as impaired control over drug use, compulsive use, and continued use of a drug despite harm or risk to the person. If this occurs, I may be referred to an addiction medicine specialist.

☐ I understand that if it appears to the Specialist in Pain Care physician/ medical provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

☐ I understand that to stop taking my pain medications abruptly may be dangerous and lead to withdrawal symptoms. If the medications need to be discontinued, I will do so gradually and only under the medical supervision of my Specialists in Pain Care physician/ medical provider.

Patient Signatures

☐ I agree to authorize Specialists in Pain Care to provide this agreement and my medical records and to discuss my condition, treatment and prescribed medications with my pharmacist and other physicians and medical providers. I also agree to sign a release authorizing my other health care providers to provide my medical record to and to discuss my treatment plan with Specialists in Pain Care.

☐ I understand that if I violate or am non-compliant with any of the above conditions, my treatment at Specialists in Pain Care may be terminated.

☐ I understand that if any violation of this agreement involves breaking state or federal law, Specialists in Pain Care may report the incident to policing and regulatory authorities.

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

Patient's Signature_____
Date_____

Witness's Signature _____
Date_____