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Informed Consent and Agreement for Treatment with Opioid Analgesic Medications

Patient Name _____ Date _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your pain management specialist to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my pain management specialist undertakes to treat me based on this Agreement. (I have agreed to use opioid analgesics (morphine-like medications) as part of my treatment for acute/chronic pain.) I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my pain management specialist is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my pain management specialist or the medication utilization review committee, may result in the termination of our physician//NP-patient relationship. In this case, my provider will stop prescribing these pain- control medicines. Also, a drug-dependence treatment program may be recommended.

1. I agree to take the medication only as prescribed and to contact my physician before any changes are made. I understand that when taken otherwise, they can cause overdose and death.

2. I will not request or accept a prescription for opioid pain medicines from any other physician or individual while I am receiving such medication from my pain management specialist.

3. If I have side effects that are related to opioid medication. I will tell my doctor immediately.

4. I am also responsible for notifying my pain management specialist immediately if I need to visit another physician or emergency room due to pain.

5. I understand that the opioid medication is strictly for my own use. I will not share, sell or trade my pain medication with anyone. If children are in the house, a childproof top is mandatory.

6. I agree to submit to urine, saliva and/or blood screens at any time as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the pain management specialist to inspect.

7. Abuse of our staff cannot and will not be tolerated. Physical and/or verbal abuse, threats, harassment, or excessive annoyance of our staff (including multiple phone calls, i.e. more than three (3) on the same day), regarding the same question or request, will unfortunately necessitate discharging the patient from our practice. If physical threats, verbal threats, or harassment occur, the proper authorities will be notified and you will be fully prosecuted by the law.

8. If you leave your appointment before the physician or NP has completed the entire visit. That is considered an automatic self-discharge.

9. I will not drink alcohol, use illegal drugs (ex: marijuana, cocaine, heroin, etc.) or take over the counter medications without talking to my doctor.

10. I understand that if I miss 3 scheduled appointment without proper cancellation notice, I may be discharged from the practice.

11. I understand that if I miss my appointment or are more than 10 minutes late your appointment will be rescheduled, I will not receive medication.

12. I should not drive or operate heavy machinery if I feel impaired in any way from any medications, even including over-the-counter medication.

13. I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Lost or stolen medicines will likely not be replaced.

14. I will receive no pain medication from any other doctor except in any emergency. (ER or admitted to hospital) I will notify my doctor right away if treated by the ER.

15. *Prescriptions must be filled* at *the same pharmacy* (as designated below). I will update my record of pharmacy should it change.

16. Pharmacy Name: _____ Phone #: _____

17. Pharmacy Address: _____

18. Refills will only be made *during regular office hours* 9am-12pm and 1pm-4pm*,* Monday through Thursday, and can be picked up only in person. Refills requested on Fridays, nights, holidays or on weekends will not be made available until the next business day. Prescriptions will not be mailed.

19. Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication.

20. Refills shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 72 business hrs. ahead to schedule pick-up for my prescriptions.

21. I will tell my doctor all of my past medical history including a history of alcoholism, prescription drug abuse, or illegal drug abuse.

22. I will bring my pill in original bottles to each visit.

23. I authorize the release of any information and medical records by the pain management specialist, his or her designee, and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the pain management specialist, his or her designee, and my pharmacy to contact any legal authority, or regulatory agency to obtain or provide information about my care or actions if the pain management specialist feels it is necessary and to cooperate fully with any city, state or federal law enforcement agency, including the North Carolina Board of Pharmacy and Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my pain management specialist to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

24. I will take appropriate steps not to become pregnant while I am in a pain management program. I also understand that if I became pregnant, or if I am suspicious that I am pregnant, I will notify the doctor and staff of the office immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold Comprehensive Rehabilitation & Pain Specialists, its shareholders, officers, directors, employees, contractors and agents harmless for injuries to the embryo/fetus/baby.

25. I understand that no agreement can anticipate all events in medical treatment which may arise and that me and my heirs, will hold harmless Comprehensive Rehabilitation & Pain Specialists, its shareholders, officers, directors, employees, contractors and agents for all resultant problems. This Agreement supersedes and replaces all previous agreements.

By signing below, I certify that I have read the above Information, I have received a copy of the contract and all my questions regarding the treatment of pain with opioid analgesic medications have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient signature: _____ Date: _____

Physician: _____ Date _____