Patient Contract for Pain Management and Medication Agreement

(Not Required If Patient is being treated with Injection Procedures Only, No Pain Medications)

This agreement between «FirstName» «LastName» (the patient) and Alliance Spine and Pain Centers (ASPC) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient to in order to receive pain management and/or pain medications. This may include care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, and biofeedback), alternative therapies, physical therapy, weight management and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. Pain medication may not completely eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:

**** Your initials are required next to each statement in the space provided.**

_____ 1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioids.

_____ 2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed to me. Prescriptions and bottle of medications must be safeguarded from loss and out of reach of children.

_____3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

_____4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids and withdrawal can be life threatening for a baby. If a female of child-bearing age, I certify that I am not pregnant, and I will use

appropriate contraceptive measures during the course of treatment with medications. Many medications could harm the fetus or cause birth defects.

_____5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

_____6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-28 hours of the last dose.

_____7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.

_____8. I agree that continued treatment and/or refill of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

_____9. I am for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances, as determined by and at the Physician's discretion and will only be bridged until the next available appointment.

A. Refill requests for medications requiring a written prescription must b called to the office 48 hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.
B. Refills will not be made after hours, at night or on weekends. This policy will be strictly adhered to.
C. Refills will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if someone else has taken some of my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
D. Refills will not be made as an "emergency". I will call my pharmacy at least 4-5 days prior to needing my prescription(s) (**for medications that do not require a written prescription**).

_____10. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my physician.

_____11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.

_____12. I will not share, sell or trade my medication or exchange medication for money, goods or services.

_____13. I will not alter my medication is any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.

_____14. I understand that changing dates, quantity or strength of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.

_____15. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

_____16. I agree that I will submit to random urine, blood, or saliva toxicology tests, if requested, to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

_____ 17. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office.

_____ 18. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

_____ 19. I will keep all scheduled follow up appointments as outlined in my treatment plan.

_____ 20. I understand that the main treatment goal using pain medications is to improve my ability to function and/or work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.

_____ 21. I understand with respect to the prescribing of my pain medications the doctors, my pharmacy, and insurers will cooperate fully with any city, state or federal agency in the investigation of any possible misuse, sale or other diversion of my pain medication as required by law, state and federal regulations.

_____ 22. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

_____ 23. I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology and/or psychological and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your physician in no way invalidates any other provisions of this agreement.

If at any time you are concerned about your medication or side effects of your medication, you may call our call center at 770-929-9033.

I agree to use _____ Pharmacy, located at _____,

telephone number _____, for all my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this _____ day of _____, 20____.

_____ _____

Patient Signature Witness

* Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.