Opioid Agreement for Center for Pain Management S.C.

Patient Name: _____

DOB: _____

I am the patient named above. I have agreed to use pain medication as part of my treatment for chronic pain. I understand that these medications may reduce my pain.

1. I understand that as a patient I have the following duties:

___ I will take my medications as prescribed. I will not change how I take my medications without the approval of providers of Center for Pain Management.
___ I will not ask for early refills. I will arrange for refills ONLY at appointments times.
___If I run out of my medications early, I will let the providers of Center for Pain Management aware of this by calling or informing them at the next patient clinic visit. I understand this may result in a discharge.
___ I will get all pain medications at one pharmacy only. I will tell the provider at The Center for Pain Management of any changes with my pharmacy:

Name of Pharmacy: _____
Location: _____
Phone: _____

___My provider at Center for Pain Management can give a copy of this Agreement to my pharmacy. My provider at The Center for Pain Management can give a copy of the agreement to any other provider I see. This may include urgent care sites or any hospital emergency room.
___ I will not ask for any pain medications or controlled substances from other providers.
___ I will tell other providers about all medications that I am taking.
___ I will communicate with The Center for Pain Management If I become pregnant.

___ I will tell other healthcare providers that I am taking pain medications. I will tell other healthcare providers that I have signed this Agreement. In case of emergency, I will give this information to the provider who is treating me.

___My provider at The Center for Pain Management can discuss my treatment with any pharmacist. My Provider at The Center for Pain Management can discuss my treatment with any other healthcare provider who is also treating me.

___ I will tell my provider at The Center for Pain Management if I develop any new medical problems and or ER visits.

___It is my job to protect my written prescriptions and medications. If I lose them, they will not be replaced. Please keep medications in a secure lock box.

___I am the only one who will use my medications. I will not give or sell them to anyone else. I will keep all medications away from children.

___If any provider asks me, I will bring all medications to my appointment. I will bring all medications, no matter who prescribed them. I will bring them in the original prescription bottles.

___I will cooperate if my provider at The Center for Pain Management as part of my treatment. These treatments may include:

- Medical evaluation or treatment
- Psychological testing or treatment
- Psychiatric testing or treatment
- Physical Therapy
- Procedures / Injections

___I will not use street drugs (including marijuana, cocaine, etc.). I will not use another person's prescriptions. I will tell my provider about any alcohol and/or drug use. I will tell my provider at The Center for Pain Management about any history of alcoholism or addictions.

___If I am in alcohol/drug treatment program, I will give my provider at The Center for Pain Management information from the program to show my progress.

___I will allow random drug testing to prove I am only taking the prescribed drugs. A random drug test is a laboratory test in which a sample of my urine or blood is checked to see what drugs I am taking. I may be charged for this test.

___I will keep all of my scheduled appointments.

___I understand that The Center for Pain Management may call me to come in for a random pill count and/or random drug screening.

__Any lost medications will not be replaced. No withdrawal medications will be given, if withdrawal symptoms occur, patients will be instructed to go to the Emergency Room. Please bring proper documentation of this visit to your appointment. Withdrawal symptoms are as follows:

Early symptoms of withdrawal include:

- Agitation
- Anxiety
- Muscle Aches
- Increased tearing
- Insomnia
- Runny nose
- Sweating
- Yawning

Late symptoms of withdrawal include:

- Abdominal cramping
- Diarrhea
- Dilated pupils
- Goose bumps
- Nausea
- Vomiting

Opioid withdrawal reactions are very uncomfortable but are not life threatening. Symptoms usually start within 12 to 30 hours depending on the narcotics prescribed.

2. I understand that my provider at The Center for Pain Management may STOP prescribing my pain medication if:
   ___My pain is not reduced or my activity level does not improve.

   ___My Provider at The Center for Pain Management thinks that the pain treatment is not working.

   ___I have side effects from the medication.

   ___I do not allow a random drug test.

   ___I do not follow through with treatments ordered by my provider at The Center for Pain Management. The treatments may include mental health, physical therapy, injections and other treatments.

   ___I miss two pain management appointments in a row. (No call, No shows to appointments and procedures).

   ___I do not follow any part of this Agreement. This may also lead to termination of medical services. Services may be terminated by this provider at The Center for Pain Management.

   Finally, our clinic has the right to discharge patients for other reasons not listed above as we see necessary.

   I have read this form or it has been explained to me. I understand ALL of the information contained in it. I have had a chance to ask questions about this form. My questions have been answered. I am signing this form voluntarily. We follow a **zero tolerance, no excuses** policy.

   I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor

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 authorizatons.

I, _____have read and understand the narcotics policy.
(Please print)

Patient Signature _____ Date: _____

Name of PCP_____ PCP Tel. No_____
(Primary Care Physician)
Name of Pharmacy_____ Pharmacy Tel. No._____

Provider Signature_____