Pain Institute

Narcotic Medication Agreement

***Please initial before each and sign at the end of the agreement**

_____ You will be receiving narcotics for the treatment of your pain. It is important that you understand the risks and responsibilities that go along with this treatment. Please read each statement carefully and sign this agreement /contract below. If you have any questions regarding this information or office policy regarding the prescribing of narcotics, please request clarification. I _____understand that any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and /or my function increase, the medication will stopped.

_____ I am aware that the use of such medications have certain risks associated with them, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, light headedness, dizziness, confusion, allergic reaction, slow breathing rate, slowing of reaction time or reflexes, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction withdrawal, and the possibility that the medication will not provide complete relief.

_____ The overuse of narcotic medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all mediation will be filled at the same pharmacy. (Should you need to change pharmacies, the clinic must be informed.) The pharmacy I have selected to use is Pharmacy_____.

_____ I cannot receive this medication by phone. I will not call the office to have a prescription called in. I am responsible for making and keeping scheduled appointments. Early refills are not permitted.

_____ I will take the narcotic medications only as prescribed. Any changes must be made by the provider and discussed with me and agreed upon. The provider has the right to increase/decrease/change medication as deemed necessary per results reported by me and by findings of my physical exam, urine drug screen results, and any other information important in the treatment of pain.

_____ Medications will not be replaced if they are lost, stolen, get wet, are destroyed, left in vehicle etc. even with police report. It is expected that you will take the highest degree of responsibility with your medication and health care. Your medication should not be left where others may see them or have access to them, especially children.

_____ Do not tell anyone that you are a patient of a pain clinic because of a high risk of stealing your medication. If anyone approaches you in the parking lot or asks you about your medication, please do not give them information even though it may seem like casual conversation. Report such activity to the clinic immediately.

_____ I agree that only my Pain Institute provider will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than the Pain Institute unless it has been discussed with the Pain Institute first. I will advise all other providers that I see to confer with the Pain

Institute Providers for any changes or need for additional narcotic medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, the Pain Institute reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

_____ I will inform my provider at the **Pain Institute** of any changes in my medication condition, any changes in my prescriptions and/or over the counter medications that I take and any adverse effects that I may experience from any medications that I take.

_____ I understand that the use of chronic narcotic medication carries the risk of addiction as well as side effects from the medication. I understand that narcotics may impair my ability to operate a motor vehicle or heavy equipment. The **Pain Institute** will not be held liable while under the influence of prescribed medications.

_____ I will not use illegal "street drugs" while receiving medication from **Pain Institute.** I will communicate fully and honestly with my providers about the character and intensity of my pain, the effect of pain on my daily life, and how well the medications is helping to relieve my pain.

_____ Random supervised urine screens will be a part of my treatment plan. I agree to have them done when the provider requests it. The prescribing provider has my permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purpose of maintaining accountability. If the responsible legal authorities have questions concerning my treatment, as it may occur that I may be obtaining or trying to obtain medications at several pharmacies, doctor shopping, etc. All confidentiality is waived and these authorities may be given full access to my records, including to be reported to the **Drug Enforcement Agency (DEA).**

_____ It is a felony to obtain narcotic medication under false pretenses. This includes getting medication from more than one provider, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). Males will need to have their primary care provider monitor testosterone levels. Females need to notify clinic of possible pregnancy to prevent birth defects and/or dependency in newborns.

_____ I will discontinue the use of all previous prescribed narcotics and pain medications unless the **Pain Institute** provider instructs me to continue them. I will take medications as prescribed. I will not break or dissolve them in a liquid, melt, crush, inject, or snort them. Potential toxicity and rapid absorption may lead to DEATH!

_____ Any patient caught sleeping or nodding off in the waiting room will have their medication decreased. Additionally, patients that come to the clinic clearly under the influence will also have their medication decreased.

_____ All patients on opioid pain medication in conjunction with benzodiazepines/CNS depressants will be counseled by a provider and required to sign the opioid and benzo use policy. Once this is signed patient will be required to: (1) titrate down off of the benzo, (2) titrate down off of the opiate, or (3) obtain letter of medical necessity from a mental health provider.

_____ I understand that narcotic medication will be stopped or tapered down if any of the following occur:

1. I trade, sell, or misuse or abuse the medications
2. The clinic finds that I have broken any part of this agreement.
3. I do not comply with a random urine test when asked.
4. My urine tests shows the presence of any medications that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving for, or the level in my system is not therapeutic for the prescription (too high/low/no metabolites for long term use).
5. If I get narcotics from sources other than the Pain Institute
6. If any member of the professional staff of **Pain Institute** feels that it is in my best interests that narcotics be stopped.
7. I display any aggressive/hostile/threatening behavior toward staff or **Pain Institute.**
8. If I consistently miss scheduled appointments.
9. If patient is called in for pill count and does not have it done.

_____ I understand that discharges are handled on an individualized basis and my provider can decide to discharge me at any time, for any reason.

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written).

I have read and understand the Narcotic Medication Agreement. By signing this agreement, I affirm that I have read, understand, and accept all terms of this agreement.

Patient Signature_____Date_____

Staff Witness_____Date_____