Advanced Physical Medicine, P.C.

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Pain agreement and Informed Consent for Opioid Therapy

I, _______________________________________ have consulted with my provider at Advanced Physical Medicine and we have agreed to try opioid pain medications (narcotics) in the treatment of my chronic pain. My provider has made me aware that the use of long acting opioids for the management of chronic pain may be ineffective. I have been informed and clearly understand the following issues in the treatment of pain with these medication, as well as other analgesic (pain relieving) or sedative medications. I am aware that failure to abide by any of these conditions will be considered a breach of this contract and may result in the termination of the patient-provider relationship.

1. **APPOINTMENTS ARE REQUIRED FOR PRESCRIPTION REFILLS/CHANGES.** Prescriptions will only be written at follow up appointments. Medications are not written during procedure appointments, any medication issues require a follow up appointment. If I cancel an appointment or miss one without calling, I understand that my prescriptions will not be refilled until I am seen in the office. I further understand that medications to assist with the symptoms of withdrawal can be written at my provider's discretion. I understand that these medications will not be called in to the pharmacy, but will be hand written.
   - **a.** The symptoms of withdrawal may include: sweating, anxiety, tremors, muscle aches, hot and cold flashes, abdominal cramps and diarrhea, nausea and vomiting.

2. **<u>Medication dosages:</u>** I understand that my provider will prescribe medication in dosages that he/she deems necessary. **I WILL NOT ADJUST THE AMOUNT OF MEDICATION I TAKE WITHOUT SPECIFIC DIRECTION FROM MY PROVIDER.** If I adjust the amount of medication I am taking and I run out early I will not be given additional medications to last until my next appointment. I understand that increasing my dose/quantity without close supervision could lead to drug overdose, causing severe sedation, respiratory depression, and death. **MEDICATIONS SHOULD NEVER BE CRUSHED, TAMPERED WITH IN ANY WAY OR TAKEN IN QUANTITIES OTHER THAN PRESCRIBED**

3. **<u>Other Drugs:</u>** I may not take other drugs such as tranquilizers, sedatives, or antihistamines without first contacting my provider. I **will not** consume alcoholic beverages or use "recreational drugs" while participating in opioid therapy. The combination of alcohol and/or recreational drugs and medications prescribed by my provider could produce profound sedation, respiratory depression, severe drop in blood pressure, and possible death. I agree to submit to random urine drug/alcohol testing at the discretion of my provider.

4. **<u>Sole Providers:</u>** My provider at Advanced Physical Medicine, P.C. will be the only provider to write prescriptions for sedative, analgesic, or narcotic medications of any sort. **I WILL NOT ACCEPT PRESCRIPTIONS FOR THESE MEDICATIONS FROM ANY PROVIDER OUTSIDE OF ADVANCED PHYSICAL MEDICINE, P.C., however, in the event that a**

surgical procedure is performed, including dental procedures, it is not a violation of this agreement if pain medications are prescribed by the performing provider, you do need to make this office aware if this occurs. It is **ILLEGAL** to take medications prescribed to someone else or allow someone else to take medications prescribed to me.

5. **Pharmacy:** I agree to use only one pharmacy to fill my medication and to accept the generic form of my medications. If my regular pharmacy is not able to dispense medication I will advise the office why and where the prescription was filled.

6. **Safe-keeping:** I understand that I am responsible for the safe-keeping of my prescriptions and medications. This means keeping them locked up in a safe secure environment that cannot be accessed by anyone else. If I lose my medication or they are stolen, I will not be given replacements or refills. I understand that I could experience the symptoms of withdrawal. **If children, pets or other adults come in contact with these medications it could potentially kill them.**

7. **Side-effects:** I have been given the handout "Opioid and Controlled Substance Side Effects, Risks, and Cautions" by my provider. I understand the risks and complications associated with the use of opioid medications. I will notify my provider if I experience any adverse side effects while taking these medications.

8. **Physical Dependency:** It is clearly understood that the use of these medications may result in physical dependence. This condition is common to many drugs such as blood pressure medications, anti-anxiety medications, and anti-seizure medications, as well as opioids.

9. **Psychological Addiction:** I understand that psychological addiction is a possible risk associated with opioid use. If I exhibit such behavior, I will be tapered off my medications and will no longer be considered a candidate for opioid therapy.

    a. Psychological addiction can be recognized by: abuse of drug(s) to obtain mental numbness or euphoria, drug craving behavior, "doctor shopping", escalating drug usage without correlation with pain relief, and manipulative behavior toward the medical provider in order to obtain prescriptions.

10. **Pregnancy:** If I am female I agree to notify the clinic if there is any possibility that I am or may become pregnant. I understand that infants born to mothers on opioid therapy will likely be physically dependent at birth and could possibly have birth defects as a result of the medications.

11. **Treatment Goal:** I understand the treatment goal is to improve my ability to function and/or work. In consideration of the goal, and that I am being given potent medication to help me achieve that goal, I agree to help myself by following better habits (i.e. exercise, weight control and the cessation of alcohol and tobacco use) and by complying with the recommendations of my provider in the use of adjunctive therapies (i.e. physical therapy, psychological counseling). I further understand that if the use of these medications does not assist me in reaching this goal or if I refuse to participate in any adjunctive therapies, I will be tapered off of these medications and other methods of pain control will be explored.

12. **Release of Information:** I agree to allow my provider to have contact with other providers, emergency departments, pharmacies, and urgent care facilities regarding this agreement. I further allow these outside entities to disclose to my provider any information required to ensure my adherence to this agreement.

13. **Random Screening:** I have been made aware that random medication/pharmacy screening will be performed regarding my opioid use. This will be done through MAPS (Michigan Automated Prescription System) as well as urine/blood screening at an outside laboratory. I understand that

a MAPS report will show all controlled medications I have received and from any/every provider. If it is found that I am receiving pain medications from other providers, this agreement will be terminated. I agree to allow my provider to contact any/all of the physicians listed on the MAPS report.

14. **Pill Counts:** This office performs random pill counts. I have been made aware that this is a screening tool used to ensure adherence to medication dosages. If I am called for a pill count, I must show up to the office when the office staff/Dr. Wilson instructs me to do so. Not returning a phone call if it is necessary for the staff to leave a message for me is considered non-compliance and is a violation of this pain agreement. Failure to show up for a pill count is grounds for termination of the patient-provider relationship.

15. **Severability:** I understand that if any provision of this agreement is determined to be invalid or unenforceable, the remainder of the agreement will remain in force.

16. **Termination:** I understand that this agreement may be terminated by either party upon 30 days written notice of the other. Delivery of such notice by U.S. Postal Service certified mail to my address of record shall be deemed sufficient notice. It is my responsibility to ensure that my provider has by current valid address. I may notify my provider of my intent to terminate our relationship in a similar fashion. I must send notice to my provider's main address.

I have read the above information (or it has been read to me). I have received a copy of the agreement and the handout "Opioid and Controlled Substance Side Effects, Risks, and Cautions". All of my questions regarding my treatment with opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

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Patient Printed Name Date __________

____

Patient Signature

____ ____________________

Physician Signature Date

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone # ______________________________________