



Medication Management Agreement & Chronic Controlled Substances / Opioid Therapy Consent

Patient's Name _____ Date _____

PLEASE READ THE ENTIRE CONTENTS OF THIS AGREEMENT

The following agreement relates to my use of non-controlled and controlled substances as part of a pain treatment plan prescribed by the Comprehensive Pain Center (CPC). The goal of pain treatment is to improve my ability to function while reducing my pain. My doctor may treat my pain with narcotics and other treatment modalities. Since narcotics are effective analgesics, they may be indicated. CPC may decide to stop prescribing for me if I am not improving, or if I cannot take my medication responsibly. If the treatment is successful, ongoing care may be necessary. Any medication prescribed is at an on-trial basis and subsequent prescriptions are contingent on benefit, progress, and willingness to try other modalities. Failure to adhere to any one policy is potentially grounds for discharge from the practice.

1. All controlled substance prescriptions must come from Comprehensive Pain Center. In cases where another physician or practitioner prescribes a controlled substance, I will call Comprehensive Pain Center prior to taking the medication for instruction.
2. I am aware of the potential for addiction to controlled substances. If this happens, I will follow my doctor's guidance and participate in an addiction treatment program if prescribed.
3. If I have any changes in my medication, medical condition, or experience any adverse side effects as a result of my medication, I will immediately contact Comprehensive Pain Center in order to avoid unwanted drug-drug interaction and side effects.
4. I understand that the physician or practitioner has permission to discuss all diagnostic and treatment details with other physicians, pharmacists, or other legal and professional representatives for purposes of my healthcare and maintaining accountability.
5. I understand that some patients develop tolerance to pain medications, and may need to increase their dose over time or change to a different narcotic to achieve the same pain-relieving effect.
6. I understand that discontinuing controlled substances abruptly may be dangerous and lead to withdrawal symptoms, such as seizures, cramps, sweats, chills and aches. I must not decrease or stop my

medications without medical supervision. I will promptly notify the Comprehensive Pain Center if I am unable to take my pain medication for more than 24 hours.

7. I understand that many medications, especially controlled substances, can interfere with my ability to drive, perform intricate tasks, and make important decisions. I understand that I should refrain from driving and other dangerous or important tasks while starting or adjusting my medication. If the manufacturer of my medication(s) recommends against operating heavy machinery, the Comprehensive Pain Center will assume no liability if I decide to do so. I am aware that I could be charged with “driving under the influence” (DUI) at any time for driving when taking controlled substances.
8. I understand that many medications, including narcotics or opioids, may harm a developing fetus. I will notify Comprehensive Pain Center as soon as possible if I become pregnant. I understand that there are numerous deleterious side effects from the general class of narcotics, examples such as: nausea, vomiting, sedation, itching, light headedness, constipation, and allergic reactions.
9. I must adhere to the following rules:
- I will use only one pharmacy to fill my controlled substance pain medications.
 - I will accept generic substitutes when available.
 - I will not adjust my medications without prior approval from Comprehensive Pain Center.
 - I will not accept prescriptions for controlled substances (pain killers or sedatives) from other doctors without prior approval or notification to Comprehensive Pain Center.
 - I will not use illegal drugs and must limit my alcohol use. My doctor will periodically ask for a urine sample to check for illegal drugs, alcohol, and other relevant pain medications.
 - If a specific medication does not work for me, I will return the unused portion to Comprehensive Pain Center.
 - I will keep my medication away from children and others. The Comprehensive Pain Center is not responsible for harm caused to another person who takes my medication.
 - I will not share, sell or otherwise permit access of others to my medication.
10. I understand that use of alcohol with my medication(s) is dangerous and could cause death from respiratory depression. I understand that other adverse side effects such as drowsiness, mental confusion, constipation, nausea/vomiting, or allergic reactions could also occur as a result of the medication(s). If an adverse side effect should occur, I will call Comprehensive Pain Center immediately.
11. I understand that other medications such as nalbuphine, pentazocine, buprenorphine, and butorphanol may act to reverse one or more medication that I am prescribed can cause feelings of withdrawal. I am responsible for reporting to other physicians trying to administer these medications that withdrawal syndrome is possible. Possible symptoms of withdrawal:
- Flu-like aching
 - Runny nose
 - Abdominal Pain / Cramping

- Diarrhea
- Nausea / Vomiting
- Irritability / Feeling of un-ease or anxiety

12. I understand that a tolerance to medications is a natural process when taking medications long-term. I understand that tolerance differs from addiction. Addiction is defined as use of a prescription(s) even if it causes bodily harm, having cravings for the medication / feeling a need for the medication, using the medication to produce feelings of euphoria or to heighten mood, and a decreased quality of life. Chances of addiction are very low in a person without extensive family or personal history of abuse. Tolerance is common in long-term treatment and may warrant incremental increases in my medication. Discontinuing a medication may cause withdrawal syndrome. I understand that both tolerance and addiction are possible and the differences between them.
13. **Men Only:** I understand that long-term opioid can cause low testosterone levels which can result in change in mood, stamina, and sexual desire. If this occurs, a blood test may be requested by your physician or practitioner.
14. **Women Only:** If I am currently pregnant, plan on becoming pregnant, or have a possibility of pregnancy, I will immediately inform both my obstetrics physician and Comprehensive Pain Center so that my care can be coordinate between the two physicians. I understand that staying on opioids during pregnancy will cause a tolerance to opioids in the baby and could lead to birth defects, although rare.
15. Stolen and lost prescriptions/medications will be replaced only once. I will protect them from theft and accidental destruction. A police report is required for all thefts.
16. I will not hold any owner or employee of the Comprehensive Pain Center liable for problems caused by my noncompliance in using controlled substances.
17. I understand that if I develop another pain condition (toothache, abdominal pain, etc.) this does not allow me to self-increase my medications. Early refills will not be tolerated.
18. Prescriptions may be issued early in certain circumstances such as traveling out of town or other circumstances beyond my control. This is under agreement of the physician or practitioner seen and me. These prescriptions will be post-dated, not to be filled until the appropriate date.
19. I agree to submit to a urine and/or blood screen to document appropriate levels of prescribed analgesics and to detect the use of non-prescribed medications at any time.
- *I understand that I may be discharged from the Comprehensive Pain Center for any positive results for illegal drugs, for a urine sample that has a temperature reading of below 90 degrees, for refusing to give a*

urine sample when requested or for not showing up at a designated off-site lab in the allotted amount of time I am given to arrive there. Controlled-substance prescriptions not prescribed by Comprehensive Pain Center or absence of those written by Comprehensive Pain Center are also potential grounds for discharge from the practice depending on the circumstance (to be determined by the physician or practitioner).

20. If any appropriate or responsible legal authorities request information regarding my care for any potential legal matter (e.g. prescription forgery, controlled-substances from multiple physicians), I understand that all medical confidentiality is waived and full access of my medical record may be granted to these authorities.
21. I recognize that therapy with controlled substances is just one part of my treatment. Other treatments, including mental health evaluation, may be appropriate for me. I agree to follow the treatment recommendations of my pain doctor, including getting exercise, tests, consultations, physical and mental health treatments.
22. Prescriptions for controlled substances are issued only during appointments, which must occur at least monthly or at the discretion of CPC. Receiving my medication(s) is contingent on keeping scheduled appointments.
23. I understand that the Comprehensive Pain Center office hours are Tuesday, Wednesdays, and Fridays, 8:00 a.m. to 5:00 p.m., excluding the lunch hours from 12:00 p.m. to 1:00 p.m. Messages left at other times will be checked frequently. The doctor may be reached directly, at other times *for emergencies only*. I will not request medications after hours or last minute, and it is my responsibility to schedule an appointment before my medication runs out.
24. The following are grounds for discharge from Comprehensive Pain Center:
- Altering or forging a prescription. This is a felony and will be reported.
 - Lying to the Comprehensive Pain Center about anything pertaining to my medical care.
 - Multiple missed appointments, late cancellations or late appearances.
 - Repeated violations of this agreement.
 - Failure to appear or to produce urine for a random drug screening.
 - Persistent noncompliance with my pain treatment plan.
 - Use of illegal drugs or substances.
 - Disruptive, threatening or violent behavior.
25. I affirm that I have full right and power to sign and be bound by this agreement. I have read, understand, and accept all its terms.
26. I authorize a copy of this agreement to be sent to my Pharmacist:

Name of Pharmacy _____
Full Address of Pharmacy (must include zip code) _____
Phone number of Pharmacy _____

27. I authorize a copy of this agreement to be sent to my Primary Care Physician:

Name of Physician: _____
Address of Physician:
(must include zip code) _____
Phone number of Physician: _____

Patient Signature

Date

Comprehensive Pain Center Witness Signature

Printed Name