Agreement on Controlled Substances Therapy for Chronic Pain Treatment

This agreement creates an understanding between me (name of patient)___________________ and Dr. Nairn, the medical director of Pain Solutions, regarding the use of controlled substances to benefit my chronic pain. The term "I" refers to the name listed above and my signature appears at the bottom of this agreement. The term providers refers to any current or future physicians or providers at Pain Solutions.

A **Controlled substance** is a type of medication that is regulated by states and the Federal government. Controlled substances include medications such as opioids (narcotic analgesics), benzodiazepine, tranquilizers, barbiturate sedatives, and muscle relaxants. While these medications can help manage pain, they can also be problematic. Some people abuse or divert these medications. Abuse is the improper use of the medications. Diversion is the sharing, trading or selling of controlled substances to ANYONE other than the person whose name is on the prescription.

Although controlled substances may be prescribed with the goal of improving your comfort and function (controlled substances therapy), these medications may cause serious side effects. You can develop an addiction disorder. Or, if you have an addiction history, you may have a relapse. Pain Solutions' providers strive to prescribe the lowest possible dose of medication that helps manage your pain and improves your function. The aim is to help you achieve a level of relief that will eventually permit you to discontinue the medications. If and when it is warranted, Pain Solutions providers will taper and eventually discontinue these medications.

Because controlled substances are often abused or diverted, patients are strictly accountable for their use of controlled substances. To help keep you safe, we require you to agree to the following policies. Throughout this agreement, the term "will" or "must" indicates an absolute condition of the agreement.

Please initial each numbered paragraph to indicate that you have read and understood it.

Purpose & Prescribing of Controlled Substances

1. I understand that Dr. Nairn has agreed to prescribe medication to help relieve my chronic pain because all other reasonable treatments for my chronic pain have failed. I have discussed the risks of use of this medication and I understand that prolonged opioid use can have adverse side effects. __________

2. The goals of the prescribed medication are:

   ☐ To improve my ability to work and function at home, work, or community;
   ☐ To help my ________________________ (name of condition) as much as possible without causing dangerous side effects. __________

3. I understand that any medical treatment is a trial, and that continued prescription is contingent on the evidence of benefit and improved function. If my pain levels remain high with no apparent relief, I understand that may be a sign that treatment is not working and medication may be discontinued. __________

4. I must get a prescription for all controlled substances from a Pain Solutions provider unless I obtain specific authorization for an exception. If I obtain medication on an emergent basis during Pain Solutions non-working hours from any other medical provider or dentist, I must inform Pain Solutions staff within 48 hours and bring in all containers of that prescription to Pain Solutions for verification. I'm aware that obtaining such prescriptions without authorization may violate this agreement. __________

5. I understand that my prescriptions are for 30 day increments. The first 30 day period will be set at my first appointment and continues from then on every 30 days. At times, I will receive my prescription a few days before the first day of the next 30 day period; however, I understand that I must not begin taking the new prescription before the final date of the previous 30 day period. If my prescription is changed, my refill date will not be affected but will remain the same. __________

6. I understand that prescription renewals are contingent on me keeping monthly scheduled appointments. I know that I must take whatever appointments are available. If I do not take an available appointment, I understand I'm not guaranteed one before my refill date and that missing an appointment does not entitle me to a short term prescription. __________

7. I understand that all copays or outstanding balances are due prior to all scheduled appointments and that if I come in without payment, I will not be able to see the provider or be given prescriptions for any medications until I pay the balance and/or my copays. __________

8. Pain Solutions' office hours are Monday, Tuesday, and Thursday from 8am-5pm and Friday from 8am-4pm. I understand that I must not phone for prescriptions after hours or on weekends. __________

Side Effects of Controlled Substances

9. I understand that this medication may cause some or all of the following side effects, and that it is MY RESPONSIBILITY TO REPORT any of these or other SIDE EFFECTS to a Pain Solutions provider and I WILL DO SO: __________

Drowsiness/Sleepiness	Slowed reflexes or reaction time	Mental confusion	Cloudiness/Impaired Judgment
Psychological and/or physical dependence or craving for the medication	Tolerance or need need for larger doses of the medication for the same effects	Constipation	Urinary Retention
Decreased Appetite	Reduced sex drive or changes in sexual function	Overdose (which could result in harm or even death	Slowing of breathing rate
Nausea, vomiting	Allergic Reactions	Failure to provide pain relief	Changes in hormonal levels

10. If I am a WOMAN OF CHILDBEARING AGE, I realize that these medications may have negative effects on the developing fetus and on the newborn child. I will inform my doctors, in advance, that I am planning to get pregnant or immediately after I discover I may be pregnant. __________

11. I will take all medications EXACTLY AS INSTRUCTED. If I develop side effects, I will immediately consult with a Pain Solutions provider or a local emergency provider. I will not stop these medications abruptly without consulting the prescribing physician, as I understand that an abstinence/withdrawal syndrome may develop. __________

12. I understand that I must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may cause drowsiness or change my mental abilities, making it unsafe to drive or operate heavy machinery. Dose changes can make medication effects stronger. If I am even slightly impaired, I will not do these activities. __________

13. I must inform Pain Solutions of any new medications or medical conditions. I understand that failure to do so may mean that my medications may interact adversely and cause additional side effects or physical or mental harm.__________

14. I understand that it is extremely dangerous while on controlled substance therapy to take illicit substances, INCLUDING BUT NOT LIMITED TO, HEROIN, COCAINE, AMPHETAMINES, OR MARIJUANA WITHOUT A MEDICAL LICENSE. Taking such substances may result in additional dangerous side effects or may enhance any side effects of controlled substance medication. I WILL NOT TAKE ILLICIT SUBSTANCES. I acknowledge that taking illicit substances will result in the immediate discontinuation of my controlled substance therapy at Pain Solutions. __________

Medication Storage

15. I must not share, sell, or give anyone else my medication. I understand that these substances may be sought by others with chemical dependency and I will closely safeguard them. __________

16. I will take the highest care of my medications and prescriptions. I will not leave them where others may see or have access to them. Since medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, I will keep them secure and out of reach. __________

17. I understand that medications will not be replaced under any circumstances, even if, accidents occur including, but not limited to, lost, flushed down the toilet, destroyed, or left on an airplane. __________

Lab Testing

18. I agree that my urine or saliva may be tested for controlled substances before initiation of therapy, and that random urine follow up testing will continue while I am prescribed controlled substances. I will cooperate in such testing. I agree that if the testing reveals the absence of my prescribed medications or the presence of unauthorized substances or illicit substances in my body, Pain Solutions providers may taper or discontinue controlled substances immediately. __________

19. I acknowledge that my insurance company may not pay for lab work for controlled substance screening and I understand that I am financially responsible and must pay for all testing. __________

Waiver of Privacy

20. I give Pain Solutions' providers permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals to coordinate my care. __________

21. I understand that if legal authorities have questions concerning my treatment, all confidentiality is waived and these legal authorities may be given full access to our records of controlled substance administration. __________

22. I understand that the practice will download, view and keep as part of my medical record Board of Pharmacy reports as to what controlled substances I am on and from whom I am obtaining them. __________

23. While I am taking controlled substances, a Pain Solutions provider may need to contact other doctors or family members and to get information about my care and/or use of this medicine, and I give them permission to do so. __________

Voluntary Termination of Care

24. I understand that if I voluntarily terminate my care by failing to keep a monthly appointment with a Pain Solutions provider, by transferring my care to another interventional pain specialist or physician for medication management, or by moving out of the state of New Mexico, I will no longer receive controlled substance therapy from Pain Solutions. __________

25. If I voluntary terminate my care in one of the ways stated in paragraph 24, I understand that I may not be accepted back to Pain Solutions for controlled substance therapy. Although I may continue as a patient with interventional treatments, there are limited spaces for controlled substance therapy. __________

Consequences of Failing to Adhere to Policies:

I understand and agree that failure to adhere to these policies may result in tapering and cessation of controlled substance prescriptions from Pain Solutions' providers or to an immediate end to services from Pain Solutions' providers after a 30-day emergency only period. ____________

I HAVE TALKED ABOUT THIS AGREEMENT WITH MY DOCTOR AND I UNDERSTAND THE ABOVE RULES.

My signature below indicates that I have read and understood these policies and my responsibilities and that I agree to and am bound by these policies:

______________________	______________________	__________
Printed Patient Name	Patient Signature	Date
______________________	______________________	__________
Printed Provider Name	Provider Signature	Date