Informed Consent Controlled Substance Agreement

The purpose of this agreement to create an understanding regarding controlled substances that may benefit your chronic pain symptoms. My goal is to treat you safely with these potent medications and to prevent abuse of or addiction to these medications. Medications such as opioids, benzodiazepines, tranquilizers, barbiturate sedatives and muscle relaxants, that may be useful in managing pain, can be problematic is several ways. Many of the medications used have common side effects such as dizziness or drowsiness, dry mouth, constipation, nausea, itching fatigue, vomiting, headache, insomnia, sweating, nervousness, confusion, falls, anxiety, edema/swelling, urinary retention, and sexual dysfunction. These medications have "street value" and potential for abuse. Although these medications may be prescribed with a goal of improving your comfort and functionality, their medical use is also associated with the risk of serious adverse effects such as development of addiction disorder or a relapse in a person with prior addiction history. The extent of this risk is uncertain, but it is known to be higher in certain vulnerable patients. My goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your pain and improving your function, and when possible, have it tapered and eventually discontinued, while at the same time monitoring and managing these potential risks.

I understand and voluntarily agree to each of the following:

I agree to keep (and be 15 minutes early) all of my scheduled appointments with the provider. If I can not keep an appointment, I will call the clinic at least 24 hours before my appointment to reschedule. If I do NOT consistently maintain my appointments with my provider, my medicine will be stop.

I will do other tests and treatments for my problem as recommended by my provider. This may include things such as counseling, physical therapy, exercises, injections, surgery and other medications.

I recognized that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended my provider to achieve increase function and improve quality of life.

I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen (a copy of the police report is required), I understand it will not be replaced until my next appointment and may not be replaced at all.

I will take my medication as instructed and not change the way that I take it without first talking to the provider or other member of the treatment team.

I will immediately call if I am having any side-effects with any of my medication. This is considered a medical emergency and should this occur after regular business hours, I will use the emergency afterhours communication system.

I will call during regular office hours (Monday-Thursday, 7:30-6:00) for medication refills. No refills on nights, holidays, or weekends. I must call at least 3 working days ahead to ask for a refill on any of my medicines. NO REFILLS ON DEA SCHEDULE 2 MEDICATIONS WILL BE GIVEN WITHOUT FIRST BEING EVALUATED BY THE MEDICAL PROVIDER.

I will call during regular business hours (M-TH 7:30-6:00) for medications that need a prior authorization. I understand that this process may take several days and I should notify the office as soon as possible to get this process started.

I will always treat the staff at the office respectfully. I understand that if I am disrespectful to the staff or disrupt the care of other patients my treatment will be stopped.

I will not sell my medicine or share it with others. I understand that if I do, my treatment will be stopped. Furthermore, I understand that the State of Virginia Drug Diversion Task Force will be notified of this activity.

I will sign a release form to let the medical provider speak to all other providers that I see, including, but not limited to practitioners of medicine, doctors, pharmacists, nurses, therapists, insurance carriers, etc.

I will tell the medical provider all other medication that I take and let him/her know right away if I have a prescription of a new medication.

I have been informed that this office DOES NOT participate with Wal-Mart pharmacies and that o prescription medications will be sent to any Wal-Mart pharmacy.

I will use only one pharmacy to all of my medications. I understand that there may be instances where a medication is not available at my chosen pharmacy and that should this happen, I will call the office and let the staff know of the pharmacy change.

I understand that my medications will be E-Scribed (electronically sent) directly to my chosen pharmacy and that written/paper prescriptions are not usually given out.

I UNDERSTAND THAT I AM NOT TO SHORT FILL ANY OF MY DEA SCHEDULE 2 MEDICATIONS (DUE TO PHARMACY STOCKING ISSUE OR INSURANCE ISSUE. IF YOU DO SHORT FILL, YOU WILL HAVE TO MAKE THE MEDICATION LAST UNTIL YOUR NEXT VISIT.

I will not get any opioid pain medications or other medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Adderall,

amphetamine) without telling a member of the treatment team BEFORE I fill that prescription. I understand that the only exception to this is if I need that medicine for an emergency at night or on the weekends.

I will not use ANY illegal drugs (examples include but are not limited to heroin, cocaine or methamphetamine). I understand that if I do, my treatment will be stopped.

I will not take or use anyone else's medications, or medications that are not prescribed to me, or take medications that have been discontinued from my current treatment plan. I understand that if I do, my treatment will be stopped.

I agree to a random drug testing and counting of my pills; this must be completed within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me and that any missed tests will be considered positive for illicit drugs.

I will keep up to date with any bills from the office and tell the medical provider or member of the treatment team immediately if I lose my insurance or can't pay for treatment.

FOR FEMALE PATIENTS ONLY:

To the best of my knowledge **I AM NOT PREGNANT.** If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment.

I accept that it is **MY RESPONSIBILITY** to inform my provider immediately if I become pregnant.

If I am pregnant or am uncertain, **I will notify my provider immediately**. All of the above possible side effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my provider harmless for injuries to the embryo/ fetus/ baby.

I have been told:
If I drink alcohol or use street drugs, I may not be able to think clearly, and I could become sleepy and risk personal injury or injury to others. I may even die.
I may get addicted to this medicine.
If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
If I need to stop this medicine, I must do so slowly or I may get very sick.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Signature: _____ Date: _____