Agreement To Receive Chronic Pain Medications

You have elected to be evaluated and treated by a provider in our office for your painful condition. Sometimes, treating pain requires the use of a treatment plan/program involving drug therapy. There are many laws and regulatory guidelines concerning the use of prescription drugs and specifically controlled substances. Thus, the purpose of this Agreement is to prevent misunderstanding about the conditions under which your provider will prescribe you medications to help you manage your pain. We use this Agreement to help both this clinic and you comply with the laws and regulatory guidelines regarding the use of controlled substances to treat pain. Please read this Agreement carefully and ask questions, if necessary. After reading the Agreement, please sign your name at the bottom of the last page, indicating your understanding of the conditions imposed upon you if you elect to undergo the recommended drug therapy program as part of your pain treatment plan/program.

Terms of the Agreement:

I understand this Agreement is essential to the trust and confidence necessary in a provider/patient relationship that my health care provider undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my health care provider will likely stop prescribing these pain-control medicines. If this happens, I understand that my health care provider will implement an appropriate plan to avoid or minimize withdrawal symptoms.

I will communicate fully with my health care provider about the character and intensity of my pain, the effect of the pain on my daily life, how well the medicine is helping to relieve the pain and how well the medications allow me to function better.

I will not use any illegal controlled substances such as cocaine, methamphetamines or the like.

I will not share, sell, or trade my medication with anyone or take anyone else's medication.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medications, from any other doctor or dentist. If an external provider is involved in issuing you a scheduled substance, prior approved from The Helm Center for Pain Management and documentation of this is required. I agree to disclose the names of my current and former health care provider and dentists.

I will safeguard my pain medicine from loss or theft. I understand my health care provider will not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my pain medication, I understand my health care provider will discuss this issue with me and he/she may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of pain

medication. I agree to these additional controls, which I understand include limitations on my supply of pain medications.

I understand my health care provider has a strict policy regarding medication refills. Specifically, I understand that my health care provider will only provide me with the refills of my pain medication during the time of my office visits or during regular office hours, subject to my valid need for the medication and not my need based on my failure to safeguard my medications, take them properly, etc. I understand my health care provider will not make refills available to me during evenings or on weekends. I understand that I am supposed to visit the emergency rooms for valid medical emergencies and not simply because I need or want more pain medication. I agree to go to the emergency room for valid medical problems, and I agree to inform my health care provider of all such visits on the next business day following any such emergency room visits.

I will inform my health care provider of my pharmacy of choice for the filling of all my scheduled pain medications.

I authorize my health care provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my health care provider and my pharmacist to talk about my pain medications and all aspects of my pain treatment plan/program, including any issues that may arise concerning potential substance abuse or diversion of pain medications. By my signature below, I agree to waive any applicable privilege or right of privacy of confidentiality with respect to these authorizations and all underlying information relating to my pain treatment plan/program and the use of controlled substances to treat my pain.

I agree to submit a blood or urine test, if requested by my health care provider. I understand my health care provider will use these tests to determine my compliance.

I agree to use my medicines as prescribed. I understand my health care provider may discontinue treating me with pain medications if I take less or more pain medication than prescribed. I also understand that my use of pain medications at a greater rate than prescribed will result in my being without this medication for a period of time.

I will bring all unused pain medicine to every office visit. I understand my health care provider or a member of his/her staff may count my unused medication(s) to ensure my compliance with my pain treatment plan/program.

I agree not to swear, abuse, or threaten the providers or their staff. I am not to call the office multiple times during the same day. This is considered harassment, and may effect the health care provider's decision to continue to provide me controlled substances or continue to retain me as a patient.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on: _____

Patient Signature: _____