Name:_____ DOB:_____ Date:_____

PAIN TREATMENT
CENTERS OF AMERICA

Pain Management Treatment Agreement

This agreement is between the undersigned (patient) and your pain management doctor. The purpose is to establish clear conditions for the prescription and use of controlled substances, specifically pain medications. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in this very specific doctor-patient relationship. The patient agrees to and accepts the following conditions for the management of prescription pain medications. The patient understands that failure to follow this agreement could result in dismissal from care.

1. Pain medication may be prescribed for me by physician listed below ONLY.
2. I will NOT attempt to obtain pain medication from any other physician without prior written notification to my pain doctor.
3. I will not, UNDER ANY CIRCUMSTANCE, take more medication than prescribed. "Running out early" will not be tolerated and NO REFILL will be GIVEN.
4. I agree to consent for random urine drug screening within 24 hours of my doctor's request.
5. I understand that I may not switch doctors in the clinic without written request.
6. I will not use any illegal substances, including marijuana, cocaine, methamphetamine, etc.
7. I will not give, share, sell or trade my medications for any reason and I will not obtain any medications from any other individual (mother, cousin, neighbor etc).
8. I will bring my pain medications to EVERY office visit in the original bottles. I will not be given a new prescription at office visit unless I have my medications in their original bottles.
9. I will not undergo any pain management procedures or injections without the consent of my pain management doctor. I understand I am free to transfer my pain management care at any time and if I chose to transfer care then I understand this new physician will assume all responsibility for my prescribed pain medications.
10. I will keep my medications in a safe place and protect against loss or theft. I understand that lost or stolen medications will not be replaced regardless of circumstance.
11. I will not exercise any disruptive behaviors to my physician or staff. I will follow medication refill policy as described.
12. I understand that an important part of my pain management program will include non-drug treatment modalities (physical therapy, injection therapy, psychiatric therapy, etc). If I fail to follow through with my doctor's entire treatment program, I understand that pain medications may be withdrawn.
13. I understand that my treatment goals are reduction in pain and improvement in overall function and quality of life. Should it become evident that these goals are not being met, I agree to stop pain medications.
14. Failure to keep appointments or rescheduling appointments more than 3 times will result in dismissal from clinic.
15. I will not use multiple pharmacies to obtain medication prescribed to me.

I understand that the long term advantages and disadvantages of chronic pain medications have yet to be scientifically determined and that treatment may change throughout my time as a patient. I understand, accept and agree that there may be current unknown risks associated with the long-term use of controlled substances. If now unknown risks become known at future time, I agree to hold Pain Treatment Centers of America, PLLC harmless.

Name:_____ DOB:_____ Date:_____

I understand that all medications have potential side effects. I have been educated to the potential side effects including, but not limited to: Physical dependence, pseudo-addiction, chemical dependence, addiction, constipation, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, breathing problems, sexual problems, and adverse effects or injury to other organs. A distinct clinical syndrome, "Opioid Hyperalgesia", has been described and can result in increased pain from continual and escalated doses of pain medication. I understand that opioid hyperalgesia is treated by weaning of pain medications. If I take more medication than prescribed, a dangerous situation could result such as coma, organ damage, or even death. I agree to take medications exactly as prescribed. I have been warned of dangers associated with pain medications, sleep aids, anxiolytics, alcohol, muscle relaxers and undiagnosed/untreated sleep apnea. I agree that I will not use these in combination and will alert all other physicians to my use of any of the above medications.

I agree to waive any applicable privileges or rights of privacy/confidentiality (including HIPAA) with respect to prescription pain medication and treatments thus authorizing Pain Treatment Centers of America (PTCOA), my referring physician, other physicians in direct contact with my care and my pharmacy to cooperate fully with each other and all city, state or federal law enforcement agency in the investigation of any possible abuse, misuse, sale or other diversion of my pain medications.

I agree to be evaluated by a psychologist or addiction specialist at any time during my treatment at my physician's request. If it is the recommendation of this specialist that I discontinue pain medications, then I agree to discontinuation of my pain medications.

(Females Only): Pain medications are felt to have minimal risk for developmental birth defects. However, if I continue these during pregnancy, my child will be born drug-dependent and will require very specialized care. I therefore agree that if I plan to become pregnant or believe that I am pregnant, I will immediately notify my physician as to determine the safest possible course of action.

REFILL POLICY

1) No early refills will be given regardless of circumstance.
2) All medication refills will be done at scheduled office visit ONLY.
3) Failure to keep office visits and subsequently running out of medication is not an emergency.
4) If an emergency arises and telephone refill request must be made – you must give our office 5 full business days to process this request and return your phone call.
5) Lost/Stolen medications will not be replaced regardless of circumstance.
6) If you have side effects from a new medication, your doctor may allow you to switch to a different medication. However, you MUST call our clinic and speak with a nurse. You will be required to return ALL of the old medication prior to being given a new prescription.

ACKNOWLEDGEMENT

I have personally read or have had the above form read to me. I understand and agree to all information contained in this document. I understand the risks of pain medication and agree to treatment. I have had a chance to ask any questions. I understand that failure to comply with any part of this document could result in immediate termination of care at Pain Treatment Centers of America.

Patient Signature _____ Date:_____

Witness: _____