

PAIN MANAGEMENT AGREEMENT

Pain Management Agreement between _____ and Peak Anesthesia and Pain Management /Advanced Pain and Anesthesia Services. _____

Print patient name

Print physician name

The purpose of this Agreement is to prevent misunderstandings regarding my treatment for chronic pain and about certain medicines I may be prescribed or pain management. This is to help both myself and my provider comply with the law regarding controlled medications, and Peak Anesthesia and Pain Management's practice policies.

This agreement relates to my use of controlled substances for chronic pain prescribed by a physician at Peak Anesthesia and Pain Management (PAPM). I have been informed and understand the policies regarding the use of controlled substances that are followed by the physicians and staff at PAPM. I understand that I may be prescribed controlled substances only if I adhere to the following conditions. My physician's goal is for me to have the best quality of life possible given the reality of my clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

Opioid is a generic term referring to medications which have been derived, either naturally or synthetically, from opium and are used for the treatment of pain. These medications are generally considered narcotics.

1. I understand that my provider and I will continually evaluate the effect of opioids and other medications and/or therapies on achieving the treatment goals and make changes as needed. I agree to take the medication at the DOSE and FREQUENCY prescribed by my provider. If I feel my prescription dose or frequency needs adjustment I will make an office visit appointment to discuss this with my provider. I agree not to increase the dose or frequency of my medications on my own and understand that doing so may result in termination of the doctor/patient relationship.
2. I will attend all appointments, treatments and consultations as requested by my providers. I will attend all refill appointments and follow pain management recommendations. Three or more missed appointments or same-day cancellations will result in termination of the doctor/patient relationship.
3. I will tell my providers about the level and quality of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
4. For female patients: If I plan to become pregnant or believe that I have become pregnant while taking medications, I am aware that, should I carry the baby to delivery while taking opioids, the baby will be physically dependent upon opioids. I will immediately call my obstetrician and PAPM to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though this is extremely rare.
5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain-control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition. If treatment for my condition is available, I agree I will not refuse treatment just to continue with opioid therapy. I understand that I have the right to refuse any procedure or therapy, but that does not mean that my provider must continue to prescribe narcotic or opioid medications.

6. I understand that a pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically-based coping strategies taught to me may lead to discontinuation of the doctor/patient relationship.
7. The risks and benefits of taking opioid medications have been explained to me. I understand them. Side effects may include skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, and impaired cognition (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing). I agree to not participate in activities that would endanger me or others while using these medications.
8. I agree to inform my physician of all medications I am taking, including herbal and over-the-counter remedies, since opioid medications can interact with them, especially cough syrup that contains alcohol, codeine or hydrocodone.
9. If I have a history of alcohol or drug misuse/addiction, I must notify my physician of this history as treatment with opioids for my pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
10. I agree I will not use any illegal controlled substances, including cocaine, heroin, methamphetamine, unlicensed marijuana, etc. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol. I agree I will not use any prescription medications obtained illegally, or obtain them from anyone, including friends or relatives. Nor will I share sell or trade my medication with ANYONE and understand that doing so will result in termination of the doctor/patient relationship.
11. I understand that I am responsible for keeping my medications in a safe and secure place, such as a locked cabinet or safe. I know I am expected to protect my medications from loss or theft. I will immediately report stolen medications to the police and my physician. If my medications are lost, misplaced or stolen, I realize that my physician may choose not to replace them or to taper and discontinue them. I understand that no opioid medications I report as stolen will be replaced without a police report.
12. I agree I will not attempt to obtain any opioid medicine from another doctor or provider without informing PAPM first. I discussed the risks of opioid medications for pain management. These risks included addiction, substance abuse, medication tolerance, physical dependence, respiratory depression, constipation, nausea, and an opiate-induced hyperalgesia state (increase in pain from opiate medications) and possible death. The patient was also advised to keep the medication in a safe place. He was advised not to drink alcohol using this medication. The patient has been informed that Advanced Pain Anesthesia Services conforms to all the recommendations from the Colorado Medical Board. Specific risks were discussed with the patient including operating a vehicle while taking opiates because of increased risk of a motor vehicle accident. We discussed how tolerance limits the efficacy of Opioids for long-term pain management. I agree to have my opioid prescriptions filled at _____, (_____) _____.
Pharmacy name/location Pharmacy phone
13. I understand that if my regular PAPM physician is unable to be present for a scheduled appointment that the other physicians and staff of PAPM will make every reasonable effort to ensure that I am able to continue my pain management program without interruption.
14. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings after 4:00 PM, or on weekends, holidays, or through an emergency or urgent care facility. Medications will not be refilled without being seen at the clinic for a regular monthly appointment.

15. I will be given a (30) thirty-day supply of my opioid prescriptions each month. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner, so I will not run out of medication. I understand that failing to do so may result in late refill as an appointment for refill may not be available prior to the refill date.
16. I understand that early refills will not be written and appointments more than five days prior to my refill date will not be scheduled. Nor will I request refills by telephone. My doctor may, at his/her own discretion, waive these rules for extenuating circumstances.
17. I agree to bring in all unused medicine when requested so that the clinic staff may dispose of it properly. I understand that I may not receive a new medication without surrendering the unused portion of any medication it is intended to replace.
18. I will submit urine, blood, or saliva for drug testing if requested by my provider to determine my compliance with their program of pain control. I understand that refusal to do so will result in the termination of the doctor/patient relationship.
19. The presence of a non-prescribed drug or illicit drug, or the absence of prescribed medications, in my urine, blood or saliva is grounds for termination of the doctor/patient relationship.
20. I authorize PAMP to cooperate fully with any official, including the state's Board of Pharmacy and local law enforcement, in the investigation of any possible misuse, sale, or other diversion of my pain medication.
21. In the event I am arrested or incarcerated related to legal or illegal drugs (including alcohol); refills of controlled substances will not be given.
22. I will accept generic brands of my prescription medications.
23. I understand that I may become physically dependent on, addicted to, tolerant or have complications from opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will accept referral to addiction specialists or a detox program.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and cravings. This means the drug *decreases* one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in lessening of one or more of a drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

25. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from a controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician.
26. I understand that if I violate any of the above conditions, my provider may choose to stop writing opioid prescriptions for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals and/or a termination of the doctor/patient relationship.
27. I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering or forging a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate and that the doctor/patient relationship will be terminated.
28. I understand that suddenly stopping some medications can cause problems such as: withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.
29. I understand that I will pay all bills and invoices due to the practice. If I fail to pay my balance due this will be grounds for termination from the practice. If terminated from the practice due to failure to pay balance you will be given a thirty (30) day supply of your medication and will receive no further medications from the practice.

Medication Refill Information:

- Advance notice of (4) four business days is required for all non-opioid prescription refills.
- Requests for scheduled refills of non-opioid prescriptions must be made through the pharmacy indicated in Number 13 above. Refills will not be made in the evening, on holidays, or on weekends.
- Most controlled substances cannot be phoned in to a pharmacy.
- I will be given a (30) thirty-day supply of my opioid prescriptions each month.
- All hard copies of opioid prescriptions must be hand delivered to the pharmacy by myself or my designated family member/caregiver.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

- This agreement supersedes all other agreements.
- By signing below I affirm that I understand AND agree to ALL the terms of the above agreement. I have full right and power to sign and be bound by this agreement. I have received a copy of this for my own reference and records.

Patient

Name

Signature

Caregiver

(Optional)

Name/Relationship

Signature

Provider

Name

Signature

Date

____/____/____

-
-
1. _____
 2. _____
 3. _____

Dismissal Letter Sent: