INTEGRATIVE PAIN CARE

MEDICATION MANAGEMENT AGREEMENT

The goal of this agreement is to ensure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for you to have the best quality of life possible given your underlying clinical condition. The success of any treatment program depends on mutual trust and honesty in the physician/patient relationship (The Therapeutic Relationship).

A member of Integrative Pain Care, LLC medical staff may prescribe federally controlled substances such as opioids (Tramadol/Ultram/etc.), sometimes called narcotics, to you for intractable pain. This decision was agreed to because of your condition and it's failure to respond to other treatments.

I agree to participate in a program of Pain Management with the Physicians of Integrative Pain Care, LLC. I may be provided with controlled substances, while actively participating in the Pain Management Program, only if I adhere to the following regulations:

__I will **ONLY** receive controlled substances from Integrative Pain Care, LLC and I understand I will **NOT** receive replacements for lost, stolen or destroyed medications.

__I will use the medications within the instructions and parameters given by Integrative Pain Care, LLC and it's staff.

__I will inform my physician of all medications I am taking, including but not limited to supplements, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains codeine.

__I will **NOT** call the office for early refills as I understand that early refills will not be filled over the phone or after normal business hours. I will be given prescriptions for enough medications to last from appointment to appointment.

__**NO** medications will be called in after normal business hours.

__I am solely responsible for keeping my pain medication in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. Stolen medications should be reported to the police and to my physician immediately. If my medications are lost, misplaced, or stolen, my physician may choose not to replace the medications or to taper and discontinue the medications altogether.

__I must bring back all opioid medications and pain medications prescribed by my physician in their original bottles.

__I may not give or sell my medications to any other person, under any circumstance, as

this is illegal. If I do, I maybe endangering that individual's health.

__Any evidence of drug hoarding, acquisition of any opiate medications or adjunctive medications from other physicians (which includes emergency rooms), unauthorized dose escalation or reduction, loss of prescriptions, or failure to follow the Controlled Substance Agreement may result in **TERMINATION** of the doctor/patient relationship and dismissal from the practice.

__I am aware that my reflexes and reaction time may be delayed when taking opioid analgesic medications and pain medications in general. I will **NOT** take part in any activity that may be considered dangerous to me or someone else, if I feel drowsy or am not thinking clearly. Such activities include, but are not limited to: Operating heavy equipment or motor vehicles, working in unprotected heights or being responsible for another individual who is unable to care for himself/herself.

__I am aware the development of addiction is much more common in persons with family or personal history of addiction. Therefore, I agree to provide my doctor with a complete and honest personal and family drug history to the best of my knowledge.

__I understand that controlled substances play a small role in the treatment of my pain condition and I am willing to participate in other integral modes of pain treatment including, but not limited to: Procedural-based treatments such as injections, physical therapy, occupational therapy, pain psychology, cognitive behavioral therapy, group counseling/therapy, biofeedback, other pain medications, chiropractic and other holistic forms of treatment. If **NO** effort is made to continue these other forms of treatment, the physician reserves the right to stop prescribing controlled substances.

__ I **AGREE** and understand that my physician reserves the right to perform random or unannounced urine drug testing. If I am requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opiate medications when applicable, or complete **TERMINATION** of the doctor/patient relationship. The presence of non-prescribed drug(s) or illicit drug(s) [cocaine, marijuana, etc.] in the urine can be grounds for **TERMINATION** of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory mandates and guidelines on the use of controlled substances to treat pain.

__I understand that the use of alcohol and opioid medications is contraindicated and dangerous.

__I **AGREE** to participate in a drug detoxification program if prescribed by a member of

the Integrative Pain Care, LLC staff.

__I **AGREE** to allow my physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions, *if my physician feels it is necessary.*

__I **AGREE** to a family conference or a conference with a close friend or significant other, *if my physician feels it is necessary.*

__Should a notice of **TERMINATION** occur, I agree to obtain an alternate source of physician care within **thirty (30) days**.

__Should a violation of this agreement occur, I will consider **thirty (30) days** adequate notice for termination of controlled substances.

__I will **NOT** seek controlled substances from Integrative Pain Care, LLC staff if I decide to discontinue participation in the Pain Treatment Program.

Controlled Substance Informed Consent

The purpose of this informed consent is to provide (you the patient) information, including the risks and benefits, about the medications you may be taking for pain. A member of the Integrative Pain Care, LLC medical staff may prescribe federally controlled substances such as opioids (Tramadol/Ultram/etc.) sometimes called narcotics, to you for intractable pain. This decision was made because your condition requires it, and has your pain has failed to adequately respond to other treatments. *By signing this document, you are confirming that you have read this consent in its entirety, that your questions have been answered, and that you have full understanding of the risks and benefits of using controlled substances to treat pain and improve function.*

__I am aware that addiction is characterized as a strong desire or sense of compulsion to take the drug; Difficulties in controlling drug-taking behavior in terms of its onset, termination, or levels of use; A physiological withdrawal state when drug use is stopped or reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms; Evidence of tolerance, such that increased doses of the drug are required in order to achieve effects originally produced by lower doses; Progressive neglect of alternative pleasures or interests because of drug use, increased amount of time necessary to obtain or take the drug or to recover from its effects; Persisting with drug use despite clear evidence of overtly harmful consequences, such as harm to the liver, depressive mood states or impairment of cognitive functioning.

__I understand that physical dependence is a normal, expected result of using these medicines for an extended period of time. I understand that physical dependence is **NOT** the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased or stopped, I will experience a withdrawal syndrome. Characteristics of opioid withdrawal include, but not limited to: Sweating, runny nose, yawning, feeling hot and cold, abdominal cramps, nausea, vomiting, diarrhea, tremor, insomnia, restlessness, anxiety, increased heart rate, increased blood pressure and dilated pupils. I am aware that opioid withdrawal is uncomfortable but not immediately life threatening.

__I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses does **NOT** always help and may cause undesirable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

__I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medication will not provide complete pain relief.

☐ (**Males Only**) I am aware that chronic opioid use has been associated with low testosterone levels. This may affect my mood, stamina, sexual desire and physical / sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

☐ (**Females Only)** I am aware that chronic opioid use has been associated with low testosterone, progesterone and estrogen levels. This may affect my mood, stamina, sexual desire and physical / sexual performance. I understand that my doctor may check my blood to see if my hormone levels are normal. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and my pain management doctor to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. Birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking opioid pain medications.

The above agreement has been explained to me (by my provider) and I agree to its terms. I understand that failure to comply with any of agreement requirements is a breach of the contract, which may subject me to immediate termination from the practice. I have read the above consent (or it has been read to me). I understand the topics, instructions, warnings, cautions, benefits and risks stated. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction and understanding. By voluntarily signing this form, I give

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my consent for the treatment of my pain with opioid pain medicines, if clinically warranted.

Patient's Name: _____

Patient's Signature: _____

Witness's Signature: _____

Physician's Signature: _____

Date of Birth: _____

Date: _____

Date: _____

Date: _____