PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substances medications (i.e. narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful for controlling both acute and chronic pain but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving quality of life, function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions.

TREATMENT GOALS

I understand that the main treatment goal is to reduce the pain to a bearable level and improve the quality of my life. This includes the ability to function and/or work. I understand that in many cases the pain may not be completely eliminated. In consideration of this goal, and because of the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

PATIENTS' RESPONSIBILITY

- I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it **will not be replaced**.

- I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.

- I will use **only one pharmacy** for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.

- I know that telephone refills are **not allowed**. **Calls or faxes from pharmacies to refill medications will not be authorized.**

- **I agree to bring the bottles of all the medications prescribed by pain management to each visit. Medications will be counted and number of refills checked**.

- I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State while taking the prescribed medications.

- At any time while I am receiving controlled substance medications, it may be deemed necessary by my doctor that I see a medication-use specialist. I understand that if I do not attend such an appointment, my medications will be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications may be tapered to completion.

- I will comply with random **PILL COUNTS**. These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breech of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the pain staff.

- I agree to undergo **random urine drug testing** at the discretion of the pain staff. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breech of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal.

- **I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medications from pain management. I will not give, share or sell my medications to any other person.**

- **I also understand that I must maintain a primary care physician while being cared for in pain management. He/She will be used to care for my other medical needs and in special cases used to write prescriptions if/when the pain management physician may be unavailable.**

REFILLS OF MEDICATIONS

- **Will be made** only during regular office hours Monday through Friday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.

- **Will not be made** if I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.

- **Will not be made** as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 24 hour in advance to schedule an appointment for refills.

RISKS OF THE CHRONIC OPIOID USE

I understand that **the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined**. My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to opioids may force my doctor to choose another form of treatment.

(Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse affects on my baby.

I have been fully informed by Dr. Rogers or his staff regarding the potential for psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired affect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are used inappropriately.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be **terminated immediately**, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. **I am responsible** for any withdrawal syndrome that may occur to do my misuse of the narcotic medications and/or termination of my care.

I have read this contract and the same has been explained to me by Dr. Rogers. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Date_____ Patient_____

Witness_____

☐ Copy given to pt. ☐ Pt refused copy. Date _____ by _____