Controlled Medication Agreement

Please initial every blank then sign and date the bottom, indicating you have read, understand and agree to abide by the following rules while receiving treatment for your pain at St. John.

Signing this contract does NOT guarantee issuance of controlled medications or use of any specific treatment option. This contract only becomes effective if the physician, at his or her sole discretion, finds controlled medication (opiate, narcotic) therapy to be appropriate. This decision is made by the physician on a patient-by-patient basis.

I understand that St. John Pain Services follows a STRICT NO TOLERANCE policy concerning rude, obnoxious or discourteous behavior of patients to the office staff or physicians. Any such behavior may result in immediate voluntary termination of our patient/physician relationship and dismissal from the clinic.

I will at all times have a primary care physician/provider for my routine medical care needs and maintain appropriate contact with my primary care physician. I will not request that my Pain Services physician treat conditions not related to pain management.

I understand that controlled medications may cause sleepiness, dizziness and occasional euphoria (happiness). I have been advised NOT TO DRIVE CARS, OPERATE HEAVY MACHINERY or expose myself or others to harmful activities while taking these medications. If over-sedation or sleepiness occurs, I will decrease my dose and contact my doctor.

I will only obtain controlled medications from one doctor. I will not seek, request or accept controlled medications from any other source. Doing such violates this contract and may result in immediate dismissal.

I will bring my medications with me to every clinic visit. In the event a medication is stopped, I will bring the remainder of the medication to the clinic for witnessed and documented disposal.

I will fill my controlled medication prescriptions at one pharmacy and provide St. John Pain Services with the contact information for my pharmacy.

Pharmacy:
Pharmacy address: __________________________________________________________
Pharmacy phone: _______________________________ Fax: __________________________

I will NOT request refills or medications on evenings, weekends or holidays or after 4 p.m. on weekdays. Requesting medications during non-approved hours is breach of contract and grounds for immediate dismissal from the clinic. I will request refill prescriptions at least three (3) business days in advance between the hours of 9 a.m. and 4 p.m. I will routinely check the announcement line as well as office postings to know when my prescribing physician will be unavailable for medication refills. It is my sole responsibility to request my medication refills in advance of my physician’s scheduled absences. I understand that by failing to do so may result in delayed refill of medications and may lead to withdrawal symptoms if I run out of medication. In the event I may run out of medications prior to the next refill, I will slowly decrease the amount of medication I am taking to “make it last” until I can obtain a refill.
I understand that I will need to present to clinic for routine office visits on a regular basis as determined by the physician. NO medication changes or additions will be made by phone or fax. ANY medication changes require an office visit, and I will willingly present to the clinic for evaluation.

I will not take my medications in any way other than as prescribed by my doctor. I will not take more of my medication than instructed by my doctor. I understand that taking more medication than prescribed is dangerous, could lead to serious health problems, including death, and is considered noncompliance and grounds for termination from the clinic. I will NOT mix my medications with other medications, alcohol or illicit “street” drugs. My doctor is the only person with authority to change my medication regimen. I will not run out of medications early. I will at no time request early refills. My doctor’s records will be used to determine appropriate time of refill. Requesting early refills is grounds for dismissal from the clinic.

I will voluntarily and immediately provide urine, blood or hair samples upon request to verify that illegal drugs are not in my system and that my prescribed medications are being used as directed. I will present to clinic for an office visit or lab work at the request of my physician.

I voluntarily give permission, with or without written consent, to background/criminal history checks and the obtaining and exchanging of my medical information with healthcare authorities by St. John Pain Services if deemed necessary by my prescribing physician.

I will protect my medications from theft or loss. In the event of theft or loss of controlled medications, I will immediately file a police report and supply my doctor with a copy of the report. The doctor is under NO obligation to replace stolen, spilled or lost medication, even though I may undergo withdrawal symptoms.

I will not sell my controlled medications or give my medications to other people. I will not steal prescriptions. I will not forge prescriptions. I will not seek controlled medications from other doctors. I will be compliant with my physician’s instructions.

I understand that at any time the physician may taper or discontinue my medications at the discretion of the physician.

I will inform my physician in the event that I become pregnant, undergo any life crisis, undergo any counseling or drug treatment, or have any major change in medical history.

I will inform the physician of any past or current use of illicit drugs, such as but not limited to marijuana, cocaine, methamphetamine, heroin, etc. I will inform the physician of any past or current use of alcohol or prescription controlled medications and of any convictions or negative consequences, both personal and legal, from the use of such substances. I will inform the physician of any history of treatment for drug/alcohol/prescription medication dependence.

I will inform the physician if I have ever been treated by another pain management doctor. I will inform the physician if and why I have ever been terminated or dismissed from another doctor or clinic.

Should I become addicted or display drug abuse/addiction behaviors as determined by my physician, I understand that my physician may discontinue my medications and refer me for drug
addiction/abuse treatment. I will comply with and follow my physician’s instructions concerning referral for such treatment. ______

I understand that my progress will be measured not only in degree of pain control. My doctor will also monitor side effects, quality of life, activity level and response to interventional therapy. If significant improvement is not occurring, the physician reserves the right to taper and stop my pain medications. ______

I understand that if I do not follow this contract and the physician’s instructions, I may put myself at risk for withdrawal. I assume the risk of drug withdrawal if I break any of the above rules and narcotics are discontinued. I understand that rapidly stopping these medications could cause me to experience withdrawal. Signs of withdrawal include altered blood pressure, sweats, nervousness, sleep disturbance, yawning, watery eyes, runny nose, anxiety, tremors, muscle aches, hot and cold flashes, stomach cramps, flu-like feelings and diarrhea. ______

I understand that failure to abide by the terms of this contract constitutes breach of contract on my part and is grounds for immediate clinic dismissal at the discretion of the physician. ______

I have reviewed this contract completely. I understand this contract. I have had the opportunity to ask questions. I agree to abide by the terms of this contract. I have also received, reviewed and accepted the terms of the “Informed Consent Opioid Therapy.” ______

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