

# Combined Prescriber-Patient Agreement & Informed Consent

This consent and agreement for treatment between the undersigned patient and prescribers at Innovative Medicine is to establish clear conditions and consent for the prescription and safe use of pain controlling opioid medications or other controlled substances prescribed by the healthcare provider for the patient.

These medications are being prescribed for the purpose of treating pain and opiate dependence in some cases. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

The Patient agrees to and accepts the following conditions for the management of pain medication or medication used to treat addiction prescribed by the Physician/Nurse Practitioner/Physician's assistant for the patient. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals of this program. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.

1. I must comply with the following guidelines:

- a. I will only use this medication for purposes of pain control and opiate dependence in some cases.
- b. I will take the prescribed medication only at the dose and frequency prescribed.
- c. I will not increase or change the dose or frequency without consulting my prescriber first.
- d. If I use my medication at a faster rate than prescribed I will be without medication for a period of time and this could result in dependence withdrawal that is uncomfortable and may include an uneasy feeling, increased pain, irritability, belly pain, diarrhea, sweats and goose-flesh and/or serious physical or psychological effects.
- e. EARLY refills may not be given.
- f. I will not attempt to get pain medication nor medication used to treat addiction from any other healthcare provider.
- g. I will inform all other healthcare providers (ER, surgeon, dentist, etc.) that I am receiving pain or addiction medications from this prescriber. Should I receive any other prescriptions for pain or addiction medication I will inform this provider of the exact medication I received by the next business day.
- h. I am expected to keep scheduled office appointments.
- i. I will obtain all medications from one pharmacy.

## Pharmacy \_\_\_\_\_

j. I am required to keep my prescriber up to date on all medications that I am taking especially other sedating medications such as medications for anxiety (Xanax, Valium, Klonopin, Lorazepam, etc.), for depression or other mental health conditions, for allergies (antihistamines that cause drowsiness such as Benadryl), for sleep: prescription (Ambien, Restoril, Lunesta, etc.) and over-the counter (Tylenol PM, etc.) for cough (Tussinex, etc.) and for muscle relaxation (Flexeril, Soma, Zanaflex, etc). The combination of these medications along with the medications we use to treat addiction and pain can result in death. Thousands of people have accidentally died this way.

k. I will consent to random drug screening at the provider's request. Unexpected results may result in changing or discontinuing my medications.

l. I agree to bring my pain medication into the office to be counted if requested.

m. I will not use this medication with any alcohol containing beverages.

n. I will not use any illegal substances including marijuana, cocaine, amphetamines, etc.

o. I will not attempt to forge or call in a prescription for myself or any other individual. I will not attempt to alter the prescription in any way written by the prescriber. I understand that these are prosecutable offenses and may be reported to the authorities.

p. If I am arrested or incarcerated related to legal or illegal drugs my medications may be discontinued.

q. I will not share, trade or sell my medication for money, goods or services. I understand that these are prosecutable offenses and may be reported to the authorities.

r. I am responsible for the protection and security of my medications. I will keep them in my possession or in a secure place at all times not allowing anyone else, including family, friends, children and at-risk adults, access to these medications.

s. If my medications are lost or stolen, a re-evaluation of my competence to continue on these medications may be performed.

2. I understand refills of my prescriptions should be addressed in person at scheduled office visits. I will not stop by the office without an appointment and I understand I will not be seen and refills will not be addressed without an appointment. Refills may not be made nights, weekends or holidays.

3. I agree to be evaluated by a psychiatric specialist, psychologist and/or addiction specialist at any time during my treatment at my doctor's request. I agree to the release of those records and reports to my prescriber. If, in their opinion I am not a candidate for further opioid treatment, I understand my medications may be weaned and discontinued.

4. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications. I authorize the Prescriber and pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of pain medication. I authorize the Prescriber to provide a copy of this agreement to my pharmacy and my other healthcare providers.

5. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.

6. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.

7. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

8. I understand that all medications have potential side effects. For pain medications these include but are not limited to: addiction, physical dependence, pseudoNonaddiction, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, "hyperalgesia syndrome", has been described in the literature and can actually result in increased pain from continual and escalated doses of opioid medication.

9. I understand if I take more medication than prescribed or combine opioids with other sedating medication or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.

10. Women of child bearing age: I understand if I am planning to become pregnant, if I become pregnant or if I am suspicious that I am pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.

I have read the above and have had all my questions answered. I know that pain and addiction can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an expected acute or subacute condition or for a specific timeframe such as a work related injury then this agreement applies to the timeframe that this provider prescribes pain medication.

Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.

I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Prescriber \_\_\_\_\_ Date \_\_\_\_\_