Agreement for Pain Management Services and Medications

Patient Name (print) _____ SS#_____ DOB_____
Address: _____ Phone: _____

- Pharmacy name/address/phone _____

Purpose of this agreement is to prevent misunderstandings about your treatment at Metro Anesthesia and Pain Management. Medications (opioids) can be very useful and helpful in controlling pain. This agreement is essential to the trust and confidence necessary in a provider/patient relationship. To insure safety and comply with regulations, I agree to the following conditions:

1. I will be truthful in reporting my history, current pain symptoms, how the medication is helping control my pain and how pain and the medication affects my life.
2. I will take my meds as prescribed and for the purpose they are prescribed. I will not share/sell/ trade medication.
3. I agree to follow my provider's advice. Controlling pain is a team effort therefore I will be expected to participate in my plan of care. Certain lifestyle changes may be requested and required of me.
4. I will be responsible for my medications by keeping them safe and secure. Stolen medication will be reported to law enforcement. Lost/misplaced/stolen medications may not be replaced.
5. I will not request nor accept controlled substances/opioids from any other physician or individual.
6. I will not use any type of illegal drugs/substances.
7. I will attend office visits on a regular basis and failure to do so will result in a refill denial. I will plan ahead.
8. I agree to random urine/blood drug testing and pill counts at the West or East Des Moines office. These must be completed within 24 hours (at the discretion of the provider) or I am discharged. Refusal to comply will result in discharge from the practice. Due to staffing, you may be required to complete your urinalysis at our East office.
9. Medication refills will be made during regular office hours from 9:00am-4:00pm Mon-Thurs and 9:00am-3:00pm on Friday. No refills on weekends, after hours, or same day. Please call one week ahead to process your request. I am responsible for keeping track of the amount left and allowing the office time to process my request.
10. I agree to use one pharmacy. If I change pharmacies, I will fill out a new agreement with corrected information.
11. I understand the risks of using opioids to include (but not limited to): Constipation, decreased appetite, confusion, problems with coordination or balance (which may make it unsafe to operate dangerous equipment or motor vehicles), drowsiness, low testosterone (males), breathing too slowly or shallow (respiratory depression), physical dependence (withdrawal will occur if I stop the medication abruptly), and/or tolerance (results in needing more medication to achieve the same pain relief). Pregnancy should be reported immediately.
12. If my medication is not controlling my pain, I agree to contact Metro Anesthesia and Pain Management. I will not "self medicate". If pain medications are used excessively, they can cause adverse effects/overdose such as vomiting, constipation, lethargy, organ failure, and even death. I will take my medication only as prescribed.
13. If I overuse my medication, I will run out early and I will be without medications until my refill is due.
14. Medications should never be used in combination with alcohol. This combination could be fatal.
15. I will obtain a yearly physical from my primary care provider including blood work to check liver and kidney function. I will notify this office of any changes/concerns in my health status.
16. If I am discharged from the practice, any family member/associations in this practice may also be discharged.
17. I understand that the *Pain Management Point System* will be enforced as long as I am a patient at Metro Anesthesia and Pain Management. I have received and reviewed the point system.

By signing this agreement, I agree that I have read, understand, and abide by the agreement. I have received a copy of the agreement for future reference. I authorize a copy of this agreement to be released to my pharmacy.

_____ _____
Signature of patient Date

_____ _____
Witness Date