



PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word “physician” is defined to include not only my physician but also my physician’s authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

The specific medication(s) that my physician plans to prescribe will be described separate from this agreement. This includes the use of medications for purposes different than what have been approved by the drug company and the government (this is sometimes referred to as “Off-label” prescribing). My physician will explain his treatment plan(s) for me.

REGARDING SIDE-EFFECTS: I understand that the most common side-effects that could occur in the use of controlled substances used in my treatment include but **are not** limited to the following: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work. I also understand that operating a motorized vehicle while taking these medications may lead to a conviction of driving while under the influence if it is determined that I am impaired.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I

will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

For female patients only: To the best of my knowledge **I am NOT pregnant.** I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant. **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

1. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medications(s) may be discontinued.
2. I will disclose to my physician **all medication(s)** that I take at any time, prescribed by *any* physician. This disclosure *will* include any herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
3. I will receive controlled substance pain medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
4. I will use **ONE pharmacy, where possible**, to obtain all controlled substances prescribed by my physician. Should the need arise to change pharmacies; Pinnacle Pain Medicine will be notified. In addition, I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

Pharmacy: _____ Phone Number: _____

5. I will use the medication(s) **exactly** as directed by my physician.
6. I **will not** use MARIJUANA for medicinal or recreational purposes while receiving controlled substance prescriptions, unless there is a change in Texas legislation to legalize it for medicinal use.
7. I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications. I **will not allow or assist** in the misuse/diversion of my medication; nor will I give or sell them to anyone else.

8. I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. I am responsible for keeping my pain medication in a safe and secure place, such as a locked cabinet or safe. Stolen medications should be reported to the police and to my physician immediately. ***If either are lost or stolen, they WILL NOT be replaced.***
9. Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. Only my prescribing physician or his/her surrogate can decide to increase my medication(s) dosage. I understand that self-medicating **will result** in running out of my medication(s) early and that I **will not** be granted an early refill.
10. I understand that **I am responsible** for providing **48 to 72 hours** notice on any refill(s). I understand that if I make a refill request after 12:00 pm it **will not** be processed until the following day, and that refill request(s) **will not** be taken on Fridays, weekends, or holidays since the on-call physician cannot prescribe these safely for me.
11. I understand that there are side effects with controlled substances which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive and/or motor ability. Overuse of controlled substances can cause decreased respiration.
12. If I have a history of alcohol or drug misuse/addiction, I **will notify** the physician of such history since the treatment with controlled substances for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for treatment of pain with controlled substances but starting or continuing a program for recovery is a must.
13. If the responsible legal authorities have questions concerning my treatment, as might occur, for example if I obtained medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to Pinnacle Pain Medicine records of controlled substances administration. In the event that I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given to you.
14. I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s) and **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 the physician feels it is necessary.
15. I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, amphetamines, cocaine, etc., this may be grounds for termination of the doctor/patient relationship at the sole discretion of my physician. If I decide not to provide a urine sample, I understand that my physician may change my treatment plan, including safe discontinuation of any controlled substances when applicable or complete 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 materials on the use of controlled substances to treat pain. I accept responsibility for the cost of the urine drug test in the event that my healthcare coverage will not cover the cost of this test.

I am also aware that my physician may refer me to the on-staff professional counselor, or that a consult with, or referral to a qualified professional, such as an addictionologist, or a professional who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy may also be provided if my physician feels it is necessary.
16. I understand that any evidence of drug hoarding, acquisition of any controlled substances from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

I CERTIFY AND AGREE TO THE FOLLOWING:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
3. **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

I understand that if I violate any of the above conditions, my prescription for controlled substances may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the use of non-prescribed illicit drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

I have read this agreement and the same has been explained to me by Pinnacle Pain Medicine staff. In addition, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from Pinnacle Pain Medicine.

Patient Signature Date

Physician Signature (or Appropriately Authorized Assistant) Date

Name and contact for the Pharmacy