TREATMENT AGREEMENT

PATIENT NAME: ______________________________________DOB:______________________

When other safer and usually helpful treatments for pain have not worked, or are not appropriate given other medical problems, controlled substance medications may be prescribed. Controlled substance pain medications (i.e. Opioids/narcotics, tranquilizers and barbiturates) are very useful, but have high potential for misuse and are therefore closely controlled by the local, state and federal government. They are intended to relief pain, to improve function and/or ability to work, not simply feel good. As the prescribing for this type of medication is being incorporated into the treatment plan to help manage my pain, I agree to the following conditions:

___ *1. I will not request or accept controlled substance medications from any other* **PHYSICIAN OR INDIVIDUAL** while I am receiving such medication. Besides being illegal to do so, it may endanger my health. The only exception is when it is prescribed when admitted to the hospital as a patient or post-operatively when previously discussed with my pain doctor. I agree to call the clinic if this happens within 24 hours of my discharge from the hospital.

___ 2. I will notify the clinic of any acute need that may require a temporary change in my opioid/narcotic medication use. I do understand that I will need written verification from a licensed provider verifying the need.

___ 3. I am responsible for my controlled substance pain medications. I will safeguard my prescribed medication from theft or loss. I understand if theft or loss occurs it ***may not be replaced.***

___ 4. I agree that I will submit urine, blood or saliva sample when requested to support the proper use of my medication. Refusal to submit a sample is reason for discontinuation of these medications or dismissal of care.

___ 5. I will bring all medications prescribed to me for pain to every office visit. Failure to do so may prevent me from receiving my medications that day.

___ 6. Prescription renewals of controlled substance pain medications.

- Will only be prescribed during regular business hours, Monday-Friday. There will be no exceptions for renewals.

- I will notify the clinic in a reasonable amount of time to schedule an appointment for prescription renewal

___ 7. It may be deemed necessary for me to see a behavioral health specialist at any time while I am receiving controlled substance medications. I understand if I do not attend this appointment that my medications may not be continued or renewed beyond an amount needed to fulfill ethical and medical standards of care. I understand that if this specialist feels that I am at risk for psychological dependence that my medications will no longer be renewed and my treatment plan will be reevaluated.

___ 8. To be prescribed controlled substance pain medications I agree with the following statements

- I do not have any current problems with substance abuse or dependence.
- I have never been and am not involved in the sale, illegal possession, diversion, or transport of controlled substance (narcotics, sleeping pills, nerve pills, or pain killers).
- I will obtain all prescriptions for controlled substance pain medications from the prescribing AMG practitioner only unless otherwise discussed.
- I will use my controlled substance pain medication at a rate no greater than the prescribed rate.
- I will not allow other individuals to consume my medication.
- I agree to allow my prescribing AMG practitioner to communicate with my referring physician, other relevant treating physicians, and pharmacists regarding my use of controlled substance pain medications.
- I will follow the instructions of my prescribing practitioner at AMG related to reducing my use of opioids/narcotics, should that be deemed necessary.
- It is my responsibility to report any side effects regarding these medications.

___ 9. I agree to use the following pharmacy ________________________located at:______________________ for my prescriptions.

___ 10. I authorize my treating AMG practitioner and the pharmacy in which the medications were filled to cooperate fully with my city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my controlled substance pain medication. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

___ 11. I have read, understand and agree to follow these guidelines. I acknowledge that I have received a copy of this agreement if I so choose.

Patient's Signature:____ Date:__________________________________

Witness:____Date:___________________________________