CONSENT for CONTROLLED SUBSTANCE and ADJUNCTS for PAIN MANAGEMENT "PAIN CONTRACT"

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Controlled substances and pain medications are very useful, but are regularly abused and have a high potential for misuse. Therefore they are closely monitored and controlled by local, state and federal governments. They are intended to relieve pain, improve function and / or ability to work, and are not intended for recreational use. The use of opioids may result in dangerous respiratory compromise or death. As a patient of Phillips Clinic, I will participate in my health care by listening to and taking the recommendations from the providers. Because the providers at Phillips Clinic may prescribe such medications and other adjuncts to help manage my pain, I will acknowledge and agree to the following conditions:

TREATMENT GOALS:

1. I understand that the main treatment goal is to improve my ability to function and / or work, and to reduce pain, therefore I agree to better health habits; exercise, weight control, avoiding use of alcohol and tobacco.
2. I must comply with the providers prescribed recommendations / treatment plan.
3. I understand that long-term advantages and disadvantages of opioid use have not been scientifically determined. My treatment regiment may change while I am a patient at Phillips Clinic.
4. In addition to chronic pain, a lot of patients also experience depressed moods. This is a serious complication that can greatly interfere with your treatment plan. Your provider will engage you about this topic and assist with any additional treatment options. These treatments may include more frequent office visits, therapeutic counseling, referrals as needed and possible additional medications; i.e. Antidepressants.

SAFETY:

1. I understand that driving a motor vehicle may not be allowed while taking some medications and is not allowed if under the influence of medications. This means if medications have altered your mental status in any way.
2. I agree that it is my responsibility to comply with Federal and State laws while taking controlled medications.
3. I have been informed that psychological dependence can, have and may occur.
4. I know that I may become physically dependent on narcotic medications. When I stop these medications, I must do so in a slow tapered manner with medical supervision to prevent withdraw symptoms.
5. I will comply with random urine, blood or breathe testing to document proper use of any medications and to confirm my compliance

RESPONSIBILITY FOR MY MEDICATIONS:

1. If lost, misplaced, stolen or taken in a manner other than prescribed, my prescription will not be replaced. If stolen, a police report will be needed for our records.
2. Individuals other than myself will not be allowed to have possession of my medications.
3. Unused portions will be returned to Phillips Clinic for disposal.
4. I am responsible for taking my medications as prescribed and keeping track of the amount remaining.
5. I am responsible to know when my individual provider will be in the office for timely refills, not on Saturday nights or Holiday weekends.
6. If I miss appointments as recommended, medications will not be refilled.
7. I will not request / accept controlled medications from other providers while under the care of Phillips Clinic providers. I will also use one pharmacy for my controlled substance medications unless certain circumstances have been discussed.

I have read this contract and understand if I violate it, Phillips Clinic will stop prescribing such controlled medications. In these cases, the provider will taper the medications down over a period of time (one month) to avoid withdraw symptoms. In addition, a drug dependent program will be recommended.

Patient Name: _____ **Patient Sign**: _____

Date: _____ **Patient #**: _____ **Witness**: _____

FAMILY PRACTICE * ANTI-AGING MEDICINE

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