Chronic Care Consultants / Pain Medication Agreement

The purpose of this agreement is to prevent misunderstanding about the pain medications you may be taking for pain management. These medications may include any one of these or a combination of NSAIDs, muscle relaxants, anti-anxiety, narcotics, antidepressants, and anticonvulsants. There are certain chronic medical or psychiatric conditions, such as insulin-dependent diabetes, inflammatory bowel disease, sleep apnea, epilepsy, depression, and panic disorder, among others, which may increase the risk of pain medication therapy. This document is to help you and our medical service to comply with the laws regarding prescriptions and controlled substances. For the purposes of this document, my consulting physician(s) referred by Chronic Care Consultants, a physician management and referral organization, as well as the company itself, will heretofore be referred to collectively as "CCC".

I _____, have agreed to the continuation of medication for intractable or chronic pain. My diagnosis (the condition causing my pain) has been explained to me by my Primary Care Physician and/or my physician at CCC. Alternative therapies were discussed with me such as physical therapy, selective spinal injections, and surgery as well. I understand that the goals of the pain medication therapy are reduction of my pain and/or improvement in quality of life.

Responsibilities

I understand the following guidelines and that I have the following responsibilities for continuing pain treatment under the care of CCC.

- I will take medications only at the dose and frequency prescribed. I will not increase or change how I take my medications without approval first.

- Prescriptions may NOT be given to anyone else other than me. I will count my remaining pills and request a follow up visit early enough to avoid a period of time without medications.

- I will fully communicate with CCC about the character and intensity of my pain, the effect of the pain on my daily life, how well the medicine is helping to relieve the pain, and any possible side effects.

- I will obtain all pain medications at my primary pharmacy, but understand if I am out of town, may use another pharmacy temporarily.

- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions may not be replaced.

- I will keep medications only for my own use and will not share them with others. I will not use illegal or street drugs. I will not share, sell, or trade my medications with anyone, or use another person's medications.

- If I have an addiction problem with drugs or alcohol, or a previous history of this problem, I will inform CCC about it.

- I agree not to drink alcohol to excess, with the understanding that the majority of deaths caused by so called opioid overdoses actually occur in combination with overdoses of alcohol and other central nervous system depressants such as Valium, Xanax, and barbiturates.

Side Effects
I understand that opioid medications may cause a variety of side effects, including, but not limited to, nausea, vomiting, itching, dizziness, constipation, sedation, dry mouth, fluid retention, weight gain, weight loss, suppression of the immune system, suppression of thyroid function, suppression of menstrual cycle, suppression of male hormone, and allergic reactions.

Addiction
I am aware that narcotics have some potential to be addictive and am willing to take that risk, as long as the benefits of treatment in my situation outweigh the risks. I understand that if I do become addicted, this is a treatable condition, and I have the right to request and be referred for treatment. I am aware that addiction is defined as the continuing use of a drug or activity in spite of harm, cravings, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I agree to immediately report any psychological cravings I may experience for the substances with which I am being treated, as well as to report any adverse consequences or side effects of their use. I agree to report to CCC any use or desire to use controlled substances for other than their intended purpose. This could include recreation, relief of stress, or getting high.

I understand that CCC may stop prescribing the pain medication if:

1) I fail to submit timely medical records.
2) CCC physician has referred me to follow up with my primary care physician more closely.
3) I develop significant side effects from the medications.
4) My behavior is inconsistent with the responsibilities outlined above, which may also result in being prevented from receiving further care from CCC.
5) If I submit altered or fraudulent medical records.
6) Give any false information.

I understand and agree with all of the above guidelines. My questions have been answered. I agree with use of these medications as outlined above.

Patient's Signature: _____
Physician's Signature: _____ Date: _____