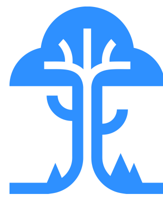

CYPRESS POINTE
PAIN MANAGEMENT

Pain Management Treatment Agreement

I ____________________________________ DOB_______________ agree to use controlled substances (narcotics/painkillers, sleeping pills) in the treatment of my pain only as prescribed for me by my CPPM physician. I understand that the goal of treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not include prescription strength medication. The overall **GOAL** will be to **DECREASE** the amount of narcotics used concurrently with other treatments. If your intention is to be treated solely with narcotic medications, then you are in the wrong pain practice.

Please **INITIAL** each item and sign below

_______ I understand that if I violate any of the terms of this agreement, my treating physician may discharge me from the practice.

_______ I understand stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack and seizures.

_______I understand that the physicians at CPPM do not write prescriptions for Soma, Xanax, Valium, or Ativan.

_______I have never been involved in the sale, illegal possession, diversion, or transport of prescribed controlled substances.

_______I am not currently abusing illicit, nonprescription drugs, or prescription drugs and I am not undergoing treatment for substance dependence or abuse.

_______ I will not misuse or abuse prescribed controlled substances, which means that I agree to take the medication as it was written for me and it will last for the period of time it was written. My medications are not to be shared, given away, or sold. I am not to take anyone else's medication. I will **NOT** go to the Emergency room for pain management of my chronic condition for which my doctor is currently treating me.

_______I will not obtain or seek controlled substances from any other physicians including dentists.

_______I consent for my doctor, his associates, and medical staff to communicate directly with my pharmacy to obtain information regarding my prescription history. I agree to waive any applicable privilege or right of confidentiality with respect to the prescribing of my pain medication. I authorize my pain management physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Louisiana Board of Pharmacy, in the investigation of my possible misuse, sale, or diversion of my pain medication; I authorize a copy of this agreement to be provided to my pharmacy and my consulting physician.

_______I will not use any other narcotic medication, other controlled substance, or illicit drugs like marijuana or cocaine and agree to provide a urine specimen upon request for toxicology screening, while under the care of the CPPM physician. I also consent to random pill counts and random urine drug screens.

_______I understand that misplaced, lost, or stolen medications or prescriptions will **NOT** be replaced and I take responsibility in safe guarding my medication and storing them properly.

_______I agree to refrain from all mind/mood altering drugs including alcohol and consent to random urine, blood, and saliva screens as well as random pill counts. My failure to comply will result in immediate dismissal from the practice. I understand that the screen results can be given to my other healthcare providers, insurance company, or other reimbursing agencies. I also authorize any healthcare provider, pharmacy, and law enforcement or judiciary body to release any pertinent information regarding my prescription or specimen results.

_______I will arrive in a timely manner for my scheduled appointments. I will be **COURTEOUS** and **RESPECTFUL** to all office staff. This includes any family member or representative speaking on my behalf. I understand that if I cancel and/or no show more than **TWO** scheduled appointments that this is grounds for

dismissal. In order to have narcotic medication refilled, in accordance with LA State Law (Act 488), I will need to be seen in an office visit a minimum of every 60 days. A refill may be written for the medication to last a period of no longer than thirty days without a refill.

_______I also understand that failure to comply with my treatment plan may result in dismissal from my treatment plan. This includes failure to attend physical therapy, failure to undergo ordered imaging such as X-rays and MRIs, and failure to attend procedure appointments; multiple re-schedules, no shows, and more than **TWO** cancellations for procedures will result in dismissal from the practice.

_______I will keep all scheduled appointments. In the event an office visit has to be cancelled I will do so with at least **24** hours notice. In the event a procedure appointment has to be cancelled I will do so with at least **72** hours notice. CPPM reserves the right to charge a cancellation fee.

_______I certify that I am not pregnant, and do not plan to become pregnant. I also certified that I am taking all precautions, which may include use of contraceptives, to prevent my becoming pregnant while undergoing treatment. In the event I become pregnant I will notify my CPPM physician.

_______I assume responsibility for operating any type of automobile, vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by my physician.

_______ I assume responsibility in making any important decisions legal or otherwise while taking controlled substances, as controlled substances can decrease mental function.

_______ I am **NOT** allowed to flush, “throw away”, “give away”, or otherwise dispose of a controlled pain medication. I **MUST** bring in any remaining medication to the office to be disposed of and documented properly by an CPPM provider. Medication changes **WILL NOT** be made unless I comply with this policy.

______I agree to adhere to all conditions from my doctor and pharmacy for safe use of my prescribed medications.

______I am responsible to make certain I do not run out of my medications on weekends, holidays, and vacations. I will not ask for my medication to be phoned in to my pharmacy. If I require a refill I will call the office **FIVE** days in advance for my request. Most medications **WILL NOT** be dispensed without an office visit. Medications are **NOT** phoned in after hours or on weekends. I also take responsibility for knowing when my refills are and making sure my follow up appointments correspond with my refill date.

______ I understand that CPPM utilizes Nurse Practitioners to see patients in follow up office visits.

______I agree to use ONLY one pharmacy__________________ ____________________ (____)__________

NAME **LOCATON** **PHONE**

______I understand that I am responsible for personally picking up my own prescriptions. If I am physically unable to pick up my prescriptions, I authorize the following person to do so on my behalf, ____________________________. This person will be required to show a picture ID as well as sign for the prescription.

_______I understand that if I refuse to initial or sign any of the items in this agreement I will NOT be prescribed any narcotic medications by my CPPM MD.

____ ____

Patient/Guardian (PLEASE PRINT) **Patient/Guardian Signature**

____ ____

Staff Signature **Date**