Patient Full Name (PRINT):___________________________ **Date of Birth**:_________________

Pain Management Treatment Agreement

The goal of this agreement is to establish and maintain a safe and controlled treatment plan. We strive to make your life as pain-free as possible, so you can return to the activities you enjoy.

Benefits:

- We provide diagnostic and therapeutic services for pain.
- We apply the latest advances in medicine to relieve pain.
- We strive to improve function and increase quality of life.
- We organize multidisciplinary approaches to manage other issues accompanying pain, if indicated.
- We provide education on the disease of pain, while providing cost-effective care.

Potential Side Effects of Opioid/Narcotic Medications:

- While all medications have possible side effects, opioid medications are potentially more dangerous with respect to side effects and/or risks. To ensure safe usage and pain control, proper monitoring through drug testing is required. The following stipulations are mandatory for all patients to receive opioid pain management treatment from CPPM.
- Potential side effects of opioid/narcotic medications include: Addiction; Appetite decrease or loss; Balance and/or coordination disruption; Confusion and/or difficulty thinking, concentrating, and focusing clearly; Constipation; Increased drowsiness/sleepiness; Respiratory depression (slowed breathing); Psychological dependence; Tolerance (needing increased amounts of medication over time).

PATIENTS RECEIVING OPIOID (NARCOTIC) TREATMENT *MUST AGREE* TO ALL OF THE FOLLOWING STATEMENTS.

OFFICE POLICIES:

☐ I will keep and arrive in a timely manner for my scheduled appointments. No-showing for more than **two** scheduled appointments or procedures is grounds for patient discharge. I must provide at least **24-hour** notice to cancel an office-visit appointment and at least **72-hour** notice to cancel an appointment for a procedure.

☐ I, and any family members or representatives communicating on my behalf, will be courteous and respectful to all office staff and will not yell, use profanity, or engage in other threatening behavior, whether in person or on the telephone or in other media, when communicating with CPPM staff.

☐ I understand that when leaving a voicemail, CPPM may require **24 business hours** to return my phone call. Leaving multiple voicemails with the same concern is unnecessary.

MEDICATIONS:

☐ I am not and will not be involved in any way in the sale, illegal possession, diversion, or transport of prescribed controlled substances.

☐ I do not have a problem with substance abuse or medication dependence.

☐ I will not use or abuse addictive or potentially addictive substances, illegal or legal (Cocaine, Alcohol, Narcotics, Marijuana, etc.). Moderate use of nicotine and caffeine are an exception to this restriction.

☐ I will not use **any** mood-modifying medication, including tranquilizers and medications for ADHD and the like, from **any** other prescriber without first discussing this with my CCPM physician, and I will not abuse such medication.

☐ I will obtain all prescriptions for opioids/Narcotics **only** from CPPM. I will only take these medications as directed.
☐ I will not **share, give, lose, or allow others to consume** my medications. I understand that CPPM does **not** replace lost or stolen medications.
☐ I understand that the physicians at CPPM do not write prescriptions for Soma, Xanax, Valium, or Ativan.
☐ I understand that stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack and seizures.
☐ I understand that my medication treatment may be discontinued if my CPPM physician feels that opioids are ineffective in relieving my pain or improving my functionality.
☐ Pharmacy: ______________________ I agree to use **only** one pharmacy to obtain opioid medications. I will notify CPPM immediately if I or my representatives use another pharmacy for any reason.
☐ I understand that I am required to follow Federal and State guidelines for medication disposal. I will consult with CPPM before **disposing** of any unused medications. CPPM will instruct me how to properly dispose of these unused medications. Medication changes **will not** be made unless I comply with this policy.
☐ I will be **subject to** random pill counts and random drugs screens and must arrive at the clinic within **24 hours** of a request by CPPM for a pill count or drug test.

ADDITIONAL TREATMENT:

☐ I will actively participate in other, additional pain therapies as recommended by my CPPM physician. I understand that treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not include prescription strength medication.
☐ I will participate in a chemical dependency program if my CPPM physician identifies a problem.
☐ I accept responsibility to gradually increase my daily activities as recommended by my physician.
☐ I understand that CPPM utilizes Mid-Level providers for follow up office visits.

OTHER MEDICAL CONDITIONS AND OTHER PROVIDERS:

☐ I will immediately notify my CPPM physician if I am or plan to become pregnant.
☐ I will not obtain or seek controlled substances from any other physicians, including dentists or emergency room physicians. If I receive medical treatment for pain for any reason, I will notify my CPPM physician immediately.
☐ I will not seek emergency treatment for the pain condition my CPPM physician is treating.
☐ I will notify any/all of my other providers of my opioid treatment by my CPPM provider. I will not accept any **pain medication** from any other provider.

PATIENT RESPONSIBILITY:

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

PRESCRIPTION REFILL POLICY:

☐ I understand that opioid prescriptions **are not refilled** without an office visit. Prescriptions for opioid refills are available only through a scheduled visit during regular office hours.
☐ I take responsibility to plan ahead, arrive for office visits as scheduled, take my medications as prescribed, and to know when my refills are due to prevent running out of medication prior to my next scheduled appointment.

PATIENT DISCHARGE/TERMINATION FROM CARE OR OPIOID TREATMENT DISCHARGE MIGHT RESULT IF ANY OF THE FOLLOWING OCCURS:

- I refuse or fail to respond to a random pill count or random drug screen by arriving at the clinic within **24 hours** of a request by CPPM.
- My CPPM physician feels that opioids or other treatment is ineffective in relieving my pain or improving my functionality.
- I share/give/sell/lose my medications or allow them to be stolen or used by others.
- I fail to take my medications as directed, or fail to actively participate in other treatments and programs recommended by my CPPM physician, or otherwise fail to follow my CPPM treatment plan and recommendations.
- I abuse other substances, legal or illegal (alcohol, cocaine, marijuana, narcotics, etc.), or take mood-altering medications not discussed and approved by my CPPM physician.
- I obtain opioid medications from sources other than the **one** pharmacy identified above, and as prescribed by my CPPM physician.
- I or my representative yell, use profanity, or engage in other threatening behavior or communications with CPPM staff.
- My CPPM physician believes I have falsely stated my compliance with this agreement or that I am not complying with the terms of this agreement.
- I terminate this agreement at any time.
- If this agreement is terminated, the patient/physician relationship will end on the date I terminate the agreement, or the date stated in CPPM's notice of termination. CPPM's notice will provide me with a written explanation of why the discharge occurred, a list of referral resources to find a new physician, and instructions for transfer of records to a new physician. During the notice period, CPPM will provide emergency treatment for the condition then under treatment by CPPM.
- If I am discharged, I cannot and will not be treated by another physician associated with CPPM.

IF I REFUSE TO SIGN THE TREATMENT AGREEMENT, I UNDERSTAND THAT I WILL NOT BE TREATED WITH OPIOIDS FOR PAIN MANAGEMENT AT CYPRESS POINTE PAIN MANAGEMENT.

I, the undersigned, attest that I have been informed, fully understand, and have had the opportunity to ask any questions about my Pain Management Treatment Agreement. I agree to all of the conditions and requirements, and I understand that failure to comply with the Treatment Agreement, as outlined by my CPPM physician, indicates I no longer agree with it, which may result in my discharge from this practice.

Patient/Guardian Signature: ______________________________ **Date:** _________________________
*If the patient is physically or legally unable to sign and a guardian signed in place of the patient, please list:

Guardian Full Name: _________________________ **Relationship to Patient**: ____________________

Physician Signatures: **Date:** _____________