CONSULTANTS IN PAIN MANAGEMENT

Patient Name: _____ DOB: _____ Today's Date _____

Medication Agreement

In order to have controlled substances prescribed for me ("pain medication", "muscle relaxants", "sleep aids", etc.), I agree with the following statements:

I WILL BRING MY MEDICATIONS TO ALL OFFICE APPOINTMENTS.

1. **I will obtain all prescriptions for narcotic medications (pain medications, sleep aids, muscle relaxants, etc.) from Dr. Gregory Ball, Dr. Arion Smalley, Dr. Sandra Kaplan, Deborah Wells, APRN-BC, Connie Terrell, APRN-BC, Lisa Gilliland, APRN-BC, Erin Stockwell, APRN-BC, Tina Johnson, APRN-BC, Dana Simpson, APRN-BC, Esli Castillo, AGACNP-BC at Consultants in Pain Management. If other controlled substance medications are required for my care, I will notify my CPM provider of any such medications prescribed for me and of the prescriber of those medications.**

2. **I will take pain medications only as prescribed by the providers at CPM.**

3. **I will not allow other individuals to take my medications.**

4. **I will inform the providers at CPM if I see another provider and receive controlled substances from them on an emergency basis.**

5. **I will consistently keep my scheduled appointments with the providers at CPM.**

6. **I will actively participate in additional pain therapies as requested by my providers at CPM and maximize the use of non-controlled medications.**

7. **I do not have a problem with substance abuse or dependency, and I agree that this may, at any time, be verified through drug screens. PLEASE INITIAL: _____**

8. **I am not and will not be involved in the sale, illegal possession, diversion or transplant of controlled substances.**

9. **I will agree to participate in a program for chemical dependency should a problem be identified.**

10. **If I am of childbearing age, I will inform the providers at CPM if I am planning a pregnancy or become pregnant.**

11. **If I feel that the medications are not working and/or are making me sick, I will bring them back to Consultants in Pain Management for destruction. I will not keep or destroy any medications on my own.**

12. **If I no show three appointments within a calendar year, I understand my chart will be reviewed by the Medical Director for possible dismissal from the practice.**

13. **I will secure my medications in a locked box or safe at all times to prevent accidental overdose by children or others for whom the medication is not prescribed and to avoid theft or diversion.**

14. **I grant Consultants in Pain Management permission to obtain and review my full prescription history from external sources.**

I understand that I must have all narcotic prescriptions filled at a Tennessee pharmacy.

I understand that treatment with narcotics may be discontinued if the providers at CPM feel that narcotics have not produced effective pain relief or an improved level of function. In that case, my provider may gradually wean me off these medications.

I understand the providers at CPM may write no other controlled substances and will recommend the patient to be admitted to in-patient detox and will help to coordinate that process **if**:

1. **I give away or sell the medications.**
2. **I lose/misplace the prescriptions or medications or if they are stolen.**
3. **I do not follow the instructions and do not take the medications as prescribed.**
4. **I obtain controlled substances from sources other than the providers at CPM.**
5. **I abuse other substances (i.e., narcotics, alcohol, marijuana, cocaine, etc.).**

I UNDERSTAND REFILLS OF MEDICATIONS WILL ONLY BE MADE DURING REGULAR OFFICE HOURS, MONDAY THROUGH THURSDAY, 8:00 A.M. TO 4:00 P.M. REFILLS WILL NOT BE MADE NIGHTS, WEEKENDS, AND HOLIDAYS. THIS REQUIRES THAT I PLAN AND CALL AT LEAST TWO BUSINESS DAYS AHEAD OF WHEN I NEED MY PRESCRIPTION.

I have read this document and understand it. The staff have answered all of my questions. I consent to the use of opioids to help control my pain, and I understand that my treatment with the opioids will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this contract, I can endanger my health as well as my life.

Violation of any portion of this medication agreement may result in dismissal from the practice.

MY PRIMARY PHARMACY IS: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____