HEALTHY LIVING PRIMARY CARE

CONSENT TO TREATMENT AND/OR DRUG THERAPY

The purpose of this agreement is for you to develop an understanding regarding the risks of taking controlled medications which include, but are not limited to **benzodiazepines**, **muscle relaxants** and **other related medications**, and the responsibilities both you and your physician have.

It has been explained to me that I have ____ (diagnosis). I understand that I am being prescribed controlled medication to help control my symptoms which **can be harmful if used without medical supervision**. I understand that the use of this medication can cause **addiction**, **dependence** and, like other medication used in the practice of medicine, produce **adverse effects**.

Common side effects and/or adverse events of **stimulants** and **other related medications** include, but are not limited to, drug interactions, increased blood pressure and heart rate, **heart attack**, **cardiomyopathy**, **sudden death** in people who have pre-existing cardiac abnormalities, palpitations, **insomnia**, anxiety, irritability, decrease appetite, nausea, vomiting, **sexual dysfunction**.

I HAVE BEEN INFORMED and understand that I will undergo medical tests and examinations both before and during my treatment. Those tests include, but are not limited to, baseline EKG, random unannounced checks for drugs with less than 24-hour notice, and psychological evaluations when deemed necessary. **I hereby give permission to perform the tests. My refusal would lead to termination of treatment.** The presence of unauthorized substances or the absence of authorized medication(s) would result in my being discharged from my physician's care.

I understand that I would be required to come in at least every 2 weeks, or monthly until the optimal dosage is reached. Afterwards, re-evaluation every 3 months, or more frequently, is needed to monitor any responses, side effects or adverse events.

______ It is **unrealistic to expect medications to control all symptoms**. We hope to **manage your symptoms** so that you can **regain function**; that is to allow you to enjoy activities that you participated in prior to the onset of your symptoms. We will continue to ask that you participate in activities that improve your ability to perform daily activities. We may, during your treatment, ask you to exercise, attend classes, or see a specialist of our choosing.

______ If necessary, I agree to see a specialist, such as psychiatrist to manage my condition or confirm the diagnosis if my primary physician recommends. Then this medication will be managed by the specialist.

______ If requested, I agree to engage in therapy to learn and use behavioral skills to cope with symptoms and plan to reduce the dosage of these medications to minimize risk of side effects and dependence.

______ <u>I am responsible for my controlled medications</u>. I agree to take the medication only as prescribed.

- I understand that increasing my dose without the close supervision of my physician could lead to drug overdose.
- I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal.

______ <u>I will not request or accept controlled medication from any other physician (including emergency room or urgent care physicians) while I am receiving such medication from my physician/health care provider</u>.

______ It is my responsibility to notify my physician/health care provider of any side effects. I am also responsible for notifying my physician immediately if I need to visit another physician or need to visit an emergency room due to uncontrolled symptoms, or if I become pregnant.

______ To the best of my ability, I will communicate fully with my physician at the initial, and all follow-up visits regarding my symptoms and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

______ I am responsible for my controlled medication prescriptions. I understand that:

- Medication name and dosage and direction: ____

- Number of pills per month: ___________ Frequency of appointments: Every ______months
- Refill prescriptions can be written for a maximum of one-month supply and will be filled at the **same pharmacy:** _______________________ Address: ____
- It is my responsibility to schedule appointments for the next medication refill before I leave the clinic or within 3 days of the last clinic visit. **No "walk-in" appointments for medication refills will be granted**.
- It is the patient's responsibility to keep track of the amount of medication remaining and to schedule appointments appropriately.
- I will be seen on a regular basis and will be given prescriptions for enough medication to last from appointment to appointment.
- Prescriptions will **<u>NOT</u>** be written in advance due to vacations, meetings, or other commitments.
- Medication **will <u>NOT</u> be refilled over the phone**. Refills **will <u>NOT</u> be made if I run out early, nor will they be filled on an emergency basis.**
- If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted.
- I am responsible for keeping my medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. Refills **will <u>NOT</u> be filled for lost prescription and/or medication**. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen, my physician may choose to NOT replace the medications, or to taper and discontinue the medications.
- **You must bring back all medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**

______ **Should your prescription need to be changed to another medication prior to your "due date", all unused medication must be brought to our office <u>prior</u> to receiving a new prescription.**

______ If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled medication, it may be discontinued. I will gradually taper my medication as prescribed by the physician.

______ If drug dependence, tolerance or addiction occurs, I agree to accept **full responsibility** for the risks taken secondary to my consent of taking such controlled medications. Signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the controlled medication.

______ If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history as this would increase the risk for addiction.

______ The use of **alcohol**, **opioids** (i.e. morphine, hydrocodone, oxycodone, Norco, Percocet), other **sedatives**, **marijuana/cannabis/CBD, cocaine**, and other **illicit drugs** together with these controlled medications **increases the risk of overdose and death.**

______ You should **NOT** use any illicit substances, such as **cocaine, heroin, ectasy, methamphetamine, LSD, PCP, and others,** and **other stimulants like phentermine, Provigil and others** while taking these medications. This would result in a change to your treatment plan, including safe discontinuation of your controlled medications when applicable, or complete termination of the doctor/patient relationship.

______ I agree and understand that my physician reserves the right to perform **random or unannounced** urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my controlled medications when applicable or complete termination of the doctor/patient relationship. The **<u>presence of a non-prescribed drug (s) or illicit drug (s) in the urine will be grounds for termination of the doctor/patient relationship.</u>** Urine drug testing is not forensic testing but is done for my benefit as a diagnostic tool and in accordance with legal and regulatory materials on the use of controlled substances to treat pain.

______ Evidence of **medication hoarding**, **increasing use of medication** without communication to the clinic staff, any **hostile behavior towards our staff**, **refilling your prescriptions too frequently**, **getting the medication from multiple physicians or pharmacies**, **increasing amounts of medications**, **medication sales**, **unapproved use of other drugs** (alcohol, opioids, sedatives or street or "illicit" drugs) during treatment, or other unacceptable behavior, will result in the termination of the use of opioid medications from our office.

______ I understand that these controlled medications are strictly for my own use. They should **never** be given or sold to others because it may endanger that person's health and is **against the law.**

______ I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions *if the physician feels it is necessary*.

______ I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary*.

______ I understand that non-compliance with the above conditions will result in a re-evaluation of my treatment plan and discontinuation of therapy. I will be gradually taken off these medications or discharged from the clinic and be provided with information for an addiction specialist. If I violate the pain contract, I will not be given any kind of controlled medication in the future from our office.

I, ______________________________ have read the above information, or it has been read to me, and all my questions regarding the treatment of ____ (condition) have been answered to my satisfaction. I hereby give my consent to participate in the medication therapy & acknowledge receipt of this document.

Patient's Name (printed) Signature: Date:

Provider's Name Signature: Date:

Witness's Name Signature: Date: