PAIN MANAGEMENT AGREEMENT

The use of controlled substances to treat pain conditions is a serious consideration. It is necessary for both you and your physician to comply with applicable state and federal laws regarding the use and prescribing of controlled substances. In order to receive a prescription for controlled substances from this practice, you must adhere to the conditions listed below.

1. **I understand that I have the following responsibilities:**
    a. I will inform my physician of all medications that I'm taking.
    b. I will take medications only at the dose and frequency prescribed and will not take any medications prescribed for other people. I will not increase, stop, or change medications without the approval of my physician. If I take more medication than what is prescribed, a dangerous situation could result, such as organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms which can be very uncomfortable or dangerous.
    c. I will actively participate in return to work efforts and in any program designed to improve function including exercise, use of non-narcotic analgesics, physical therapy, psychological counseling, or other therapies or treatment.
    d. I will not request opioids or any other pain medicine from other physicians.
    e. I will not be involved in the sale, illegal possession, or diversion of controlled substances. I will not use illegal substances, street drugs, or abuse alcohol while taking controlled substance medications.
    f. I will obtain all medications from one pharmacy, when possible, with full consent for an APC physician to talk with the pharmacist.
    g. I am personally responsible for securing my medications. I acknowledge that Advanced Pain Consultants recommends securing my medications in a lockbox or safe, removing only one day of medications at a time.
    h. I agree to travel only with enough medications for the duration of my trip keeping them in an appropriately labeled prescription bottle.
    i. If my medications are lost or stolen, I understand that the physician may replace the missing medications, one time only, if a copy of the police report of the theft is submitted to the office.
    j. I consent to have my prescription history reviewed, including Illinois and other states prescription monitoring programs.
    k. I understand the possible complications of chronic narcotic therapy include: chemical dependence (addiction), constipation severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and reduced sexual function.
    l. I certify that I am not pregnant and will notify my physician if I become pregnant. I recognize that being pregnant, there are risks to the unborn child which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth.
    m. In the event of an emergency, I agree to request the emergency room or other treating physician contact my doctor to discuss any pain or opiate related issues; no more than three days of medications may be prescribed by the emergency room or other physician without this doctor's approval; contact the practice within 24 hours if an unavoidable emergency occurs requiring a prescription for controlled substances, ER visit, or hospital admission; sign a consent to request record transfer to this doctor.
2. I consent to random drug testing and pill counts at the discretion of my doctor. I understand that the drug test is a two-step process, with the initial drug screen completed in the office, and a second more conclusive test performed by an outside laboratory. This two-step process allows my doctor to prescribe medications at the time of my appointment.
3. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.

4. Understand that the benefits of narcotic medications will be evaluated regularly using criteria for pain relief including but not limited to increased functionality, increased general function, improvement in pain levels, feedback from family and friends, absence of side effects, and if possible return to work.
5. I understand that this doctor may stop prescribing opioids, or change the treatment plan if:
    a. I do not show any improvement in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlined in this agreement.
    c. I give, sell or misuse the opioid medications.
    d. I develop rapid tolerance from the treatment.
    e. I obtain opiates from anyone other than this doctor.
    f. I refuse to cooperate when asked to submit to a drug screen.
    g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
    h. If I repeatedly miss appointments, procedures or other treatments.
6. I will under no circumstances hold Advanced Pain Consultants nor its physicians liable for any sequelae of discontinuance of controlled substances provided 30-day notice of termination is given.
7. **I have read this agreement, understand it, and have had any questions answered satisfactorily. I agree to comply with the terms of this agreement.** I understand that if I do not comply, I may not receive further prescriptions for controlled substances, my doctor will taper off the medication, and a drug dependence treatment program may be recommended. I have received a copy of this agreement.

_______________________________________	____	_________
Patient Printed Name	**Patient Signature**	**Date**