Advanced Pain Institute, LLC

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PAIN MANAGEMENT TREATMENT AGREEMENT

When other pain management treatment options are unavailable or have proven ineffective, opioid (narcotic) medications may be considered to improve quality of life, as well as the ability to function and work. 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 pain management treatment at the Institute.

NON-COMPLIANCE WITH ANY ONE OF THESE CONDITIONS MAY RESULT IN DISCHARGE FROM THE PRACTICE.

POTENTIAL SIDE EFFECTS OF OPIOID (NARCOTIC) MEDICATIONS:

The following list includes the most common, but not all, side effects associated with the use of opioid medications:

- Addiction (cessation triggers withdrawal symptoms such as increased pain, agitation, nausea, diarrhea)
- Appetite decrease or loss
- Balance and/or co-ordination disruption
- Confusion and/or difficulty thinking, concentrating, focusing clearly
- Constipation
- Increased drowsiness/sleepiness
- Respiratory depression (breathing too slowly)
- Psychological dependence (cessation triggers craving/depression)
- Tolerance (pseudo-addiction; increased amounts of a medication are needed to control pain)

PATIENTS RECEIVING OPIOID (NARCOTIC) TREATMENT MUST AGREE TO ALL OF THE FOLLOWING:

- **I WILL OBTAIN *ALL* PRESCRIPTIONS FOR OPIOIDS (NARCOTICS) *ONLY* FROM ADVANCED PAIN INSTITUTE (API).**
- **I WILL USE *ONLY ONE PHARMACY* *TO FILL OPIOID PRESCRIPTIONS:* _____.**
- **I WILL IMMEDIATELY NOTIFY MY API PHYSICIAN IF FOR ANY REASON ANOTHER PHARMACY IS USED.**
- **I WILL *TAKE ALL MEDICATIONS* PRESCRIBED BY MY API PHYSICIAN *ONLY AS DIRECTED.***
- **I WILL NOT *SHARE, GIVE, ALLOW OTHERS TO CONSUME OR PHYSICALLY REMOVE* MY MEDICATIONS.**
- **I UNDERSTAND THAT API DOES *NOT* REPLACE LOST OR STOLEN OPIOID (NARCOTIC) PRESCRIPTIONS/MEDICATIONS.**
- **I WILL NOT ACCEPT ANY PAIN MEDICATION FROM ANOTHER PHYSICIAN.**
- **I WILL NOTIFY ANY/ALL OTHER PHYSICIANS OF MY OPIOID TREATMENT PRESCRIBED BY MY API PHYSICIAN.**
- **I WILL NOT SEEK EMERGENCY TREATMENT FOR THE CHRONIC PAIN CONDITION MY API PHYSICIAN IS TREATING.**
- **I WILL IMMEDIATELY NOTIFY MY API PHYSICIAN IF I RECEIVE EMERGENCY/OTHER MEDICAL TREATMENT FOR ANOTHER REASON.**
- **I WILL KEEP ALL OFFICE APPOINTMENTS. OPIOID PRESCRIPTIONS ARE NOT REFILLED WITHOUT AN OFFICE VISIT AND I MAY EXPERIENCE MEDICATION WITHDRAWAL SYMPTOMS IF I MISS MY APPOINTMENT.**
- **I WILL ACTIVELY PARTICIPATE IN OTHER, ADDITIONAL PAIN THERAPIES AS RECOMMENDED BY MY PHYSICIAN.**
- **I ACCEPT RESPONSIBILITY TO GRADUALLY INCREASE MY DAILY ACTIVITIES AS RECOMMENDED BY MY PHYSICIAN.**
- **I DO NOT NOW, NOR HAVE I EVER, HAD A PROBLEM WITH SUBSTANCE ABUSE OR MEDICATION DEPENDENCE.**
- **I WILL PARTICIPATE IN A CHEMICAL DEPENDENCY PROGRAM IF MY API PHYSICIAN IDENTIFIES A PROBLEM.**
- **I DO NOT NOW, NOR HAVE I EVER, ILLEGALLY POSSESSED/SOLD/DISTRIBUTED/DIVERTED/OR TRANSPORTED CONTROLLED DRUG SUBSTANCES.**
- **I AM NOT PREGNANT, HOWEVER I WILL NOTIFY MY API PHYSICIAN IMMEDIATELY IF I BECOME PREGNANT.**
- **I UNDERSTAND I WILL BE SUBJECT TO RANDOM DRUG TESTING AND RANDOM PILL COUNTS. IF I REFUSE MY API PHYSICIAN HAS THE RIGHT TO WITHHOLD ANY/ALL MEDICATION, AS WELL AS DISCHARGE ME FROM THE PRACTICE.**
- **I WILL BE COURTEOUS AND RESPECTFUL TO OFFICE STAFF AND OTHERS ASSISTING WITH MY TREATMENT.**

OPIOID TREATMENT WILL BE DISCONTINUED IF ANY OF THE FOLLOWING OCCUR:

- **MY API PHYSICIAN FEELS THAT OPIOIDS ARE INEFFECTIVE IN RELIEVING MY PAIN OR IMPROVING MY FUNCTIONALITY.**
- **I VIOLATE THIS AGREEMENT BY SHARING/GIVING/SELLING/LOSING MY MEDICATIONS, OR ALLOWING THEM TO BE STOLEN.**
- **I FAIL TO TAKE MY MEDICATIONS AS DIRECTED.**
- **I OBTAIN OPIOID MEDICATIONS FROM SOURCES OTHER THAN MY API PHYSICIAN.**
- **I ABUSE OTHER SUBSTANCES, LEGAL OR ILLEGAL (ALCOHOL, COCAINE, MARIJUANA, NARCOTICS, ETC.).**

- **IF ANOTHER CONDITION ARISES THAT PROHIBITS/CONTRAINDICATES CONTINUING OPIOID TREATMENT.**

PRESCRIPTION REFILL POLICY

- **OPIOID PRESCRIPTION REFILLS ARE AVAILABLE ONLY THROUGH A SCHEDULED VISIT DURING REGULAR OFFICE HOURS, MONDAY-FRIDAY, 8:00 A.M. – 5:00 P.M.**
- **IT IS MY RESPONSIBLITY TO PLAN AHEAD, ARRIVE FOR OFFICE VISITS AS SCHEDULED AND TAKE MY MEDICATIONS AS DIRECTED TO PREVENT RUNNING SHORT OF MEDICATION BEFORE MY NEXT APPOINTMENT.**

AUTHORIZATION AND CONSENT

I consent for my API Physician and office staff to communicate directly with my pharmacy or other organizations 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 API 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 other health care providers as needed.

I understand that the random drug screen testing results may be released to my other healthcare providers, insurance company, or other reimbursing agencies. I also authorize any other healthcare provider, pharmacy, and law enforcement or judiciary body to release any pertinent information regarding my prescriptions or urine/blood drug screen testing results.

My failure to follow the Treatment Plan as outlined by my API physician indicates I no longer agree with the Treatment Plan and will result in my being discharged from the practice.

If I refuse to sign the treatment agreement, I understand that I WILL NOT be treated for pain management at Advanced Pain Institute

Termination Clauses

My API Physician may terminate this agreement at any time if he/she believes 1) I am not complying with its terms, 2) if I have made a material misrepresentation or false statement concerning my pain or 3) falsely stated my compliance with the terms of this agreement.

The patient may terminate this agreement at any time.

If this agreement is terminated, the doctor/patient relationship is terminated and the patient will be formally discharged from the facility. Thus, the patient cannot and will not be treated by another physician associated with this practice.

I, the undersigned, attest that the above agreement was discussed with me, and I fully understand and agree to ALL of the conditions, requirements and instructions. I also understand that failure to comply with the above may result in my discharge from this practice.

Print Patient Name: _____ _____ Date: _____/_____/20_____

Patient/Guardian Signature: _____Witness Signature: _____

Authorization for Treatment

I hereby authorize the physician(s) of the Advanced Pain Institute to disclose any or all of the information in my records to any person, corporation or agency which is or may be liable for all or part of the Advanced pain Institute's charge or who may be responsible for determining the necessity , appropriateness, amount or other matter to the health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the social security administration or it's intermediaries or carriers. I understand that my medical records may contain information that indicates that my have a communicable disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity and release the Advanced Pain Institute, its agents, and its employees from liability in connection with the release of the information contained therein.

Miscellaneous:

Fee for Disability Forms/Scooters/other info will be $**75.00**. Fee for Handicap license plate/sticker will be $**20.00** due before forms are completed.

Patient/Guardian Signature:_____

Date:_____/_____/_____