

MANHATTAN PAIN MEDICINE, PLLC

CONTROLLED SUBSTANCES THERAPY CONTRACT

Adapted from a consent form from the American Academy of Pain Medicine

The purpose of this agreement is to protect the patient's access to controlled substances and to protect the physician's ability to prescribe for the patient.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. You acknowledge that you are receiving a controlled substance for the treatment of pain, and that the continuation of this therapy is contingent on your adherence to the following conditions.
2. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____
4. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
5. You will take the medication as prescribed. The medication may not be taken more often, or in greater dose, than it was prescribed. Uncontrolled pain requires a follow-up visit for dose adjustment.
6. You will participate in your full treatment plan, including non-opioid modalities such as other medications, procedures, and/or therapies, as prescribed in conjunction with the opioid therapy.

7. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability
8. You may not share, sell, or otherwise permit others to have access to these medications.
9. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop. You agree to contact your doctor if you wish to stop your medication, or if you experience any symptoms of withdrawal.
10. You will remain abstinent from recreational drugs and alcohol.
11. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder, immediate weaning or discontinuation of the prescribed substance, and/or discharge from the clinic.
12. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
13. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
14. Original containers of medications with the remaining medication should be brought in to each office visit.
15. It is your responsibility to safeguard your medication. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
16. Early refills will generally not be given. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
17. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
18. Renewals are contingent on keeping scheduled appointments. If an appointment is missed, it is the patient's responsibility to reschedule prior to running out of medication. The physician is not responsible for any ill effects resulting from the patient missing, or not scheduling, a follow-up appointment.

- 19. Appointments must be scheduled. Walk-ins are not allowed.
- 20. Prescriptions will not be refilled outside of business hours, including weekends, holidays, and off hours. Any request during these times will constitute a breach of this contract, and the controlled substance may be weaned or discontinued immediately. It is the patient's responsibility to ensure adequate medication supply between appointments.
- 21. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit as determined by the prescribing physician (i.e. improvement in physical functioning).
- 22. The dosage of medication may be changed, or the medication may be weaned at any time at the sole discretion of the prescribing physician.
- 23. It is understood that failure to adhere to these policies may result in immediate cessation of therapy with controlled substance prescribing by this physician and/or referral for further specialty assessment.
- 24. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Patient name (print): _____

Signature: _____ Date: _____

Physician Signature: _____