Integrated Pain Solutions

FOR ACTIVE LIVING

Patient Treatment Agreement / Patient Accountability Letter

Date: ___/_____/2020____ Patient: _____
DOB:_____

The purpose of this agreement is to establish accountability measures for you in connection with this office's treatment of your chronic pain condition. We believe the accountability measures protect your access to the controlled substances you and your doctor's ability to use controlled substances to treat your pain. The ultimate responsibility for management of your pain is placed upon you – the patient. Our responsibility is to help you become as effective a manager of the pain experience as possible. You must learn to decrease your reliance on pain medications as much as possible and to focus more on issues of minimizing suffering, changing attitudes and lifestyle, reducing disability, and accepting responsibility for your own health situation. We do not intend for this agreement/letter to suggest that you have a problem using pain medications. We use these agreements/letters routinely and believe them to be a necessary component of quality medical care.

Reminder about Clinical Treatment Plan

Your doctors (or Physicians Assistant or Nurse Practitioner) are working with you to develop a clinical treatment plan to help you with your pain. The goals of the treatment plan are to decrease your pain level and to improve your functional activities. Your doctor may ask you to participate in physical therapy, psychological counseling, biofeedback, or other treatment methods. Your doctor will explain these treatment methods, and other alternatives, throughout the course of your treatment program with this office. ***Remember, you also have a responsibility to ask questions of your doctor and our staff if you do not understand what is expected of you under this agreement or if you want more information about the risks and benefits of all the treatment methods available to treat your pain.***

Reminder about Informed Consent for Use of Pain Medications

If you and your doctor decide that it is appropriate for you to use controlled substances to treat your pain, it is important for you to understand that the long-term use of controlled substances, such as opioid analgesics (pain medication), benzodiazepines, tranquilizers, barbiturate sedatives, and other pain medications or mood-altering medications, is widely accepted, but somewhat controversial because of uncertainty regarding the extent to which they provide long-term benefits. Likewise, there is some controversy as to the effectiveness of their use with certain disease processes or syndromes.

If you elect to use controlled substances to treat your pain, you should know the use of these medications present risks and benefits. We explained these risks and benefits to you, along with treatment alternatives, in a document called "Informed Consent for Opioid Treatment." You signed this document and you should review your copy of it along with this document. Please feel

free to ask questions throughout the course of your treatment with this office.

Statement of Accountability Terms

Pain medications have potential for abuse or diversion. Thus, we require all of our patients to follow the rules described below and we believe in "strict accountability." By your signature below, you agree to follow these rules and you acknowledge that you understand the consequences (explained below) of your failure to follow them.

1. You will show up for all scheduled appointments for re-evaluation.

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After the initial medication trial period, you will be re-evaluated at least once every month. Our office policy is that *all re-evaluations will be scheduled appointments, not walk-in appointments*. ***Initial____***

2. At every office visit and in every event of communication (including telephone calls and written communications), you agree to give a complete, honest self-report of (a) pain relief, (b) activity level (function), (c) adverse effects (side-effects and related negative impact on your health related to the use of the medication), and (d) drug usage. ***Initial__***
3. We will not make any changes to your prescriptions by telephone. You must appear in person and you will not be permitted to change your medication dosage amounts without prior authorization from your prescribing doctor. You understand that one doctor will assume responsibility for prescribing your pain medication, and no other doctor will prescribe these medications to you. If your prescribing doctor is unavailable, a substitute doctor may decide to prescribe you controlled substances, subject to your treatment plan and the remaining rules in this agreement. You understand that you may not obtain pain medications from any other doctor, a dentist, or other health care provider for the treatment of pain. If, for some reason, you encounter an emergency situation and are given controlled substances by a health care professional, you agree to report the facts of this matter and you consent to the disclosure of all personal health information related to the matter.
4. We both have responsibility to control your supply of pain medication. Our responsibility is to ensure that you have pain medication available to treat your pain. The law allows us to prescribe controlled substances to you when there is (1) a legitimate medical purpose, and when it is (2) the usual course of professional practice to prescribe such medications. Your responsibility is to take your medication only as prescribed and to keep it safe from the accidental use and unlawful misuse by others. For these reasons, you agree to keep a daily record of all medication taken. You will bring your medication log to each office visit and present it to your prescribing physician and psychologist (or psychiatrist), where applicable, for their review. You will also bring all of your medications in their original bottles to each office visit, so someone on our staff can count your medication to ensure proper usage.
5. You agree to have all of your controlled substance prescriptions filled at one pharmacy. You have indicated to us that you wish to use the following pharmacy:_____. If you need to change your pharmacy, you agree to notify us immediately of the change.
6. You agree to report significant side effects due to your use of any medication we prescribe to you. For example, if you experience over sedation, nausea, vomiting, constipation, confusion, euphoria (high feelings), and dysphoria (down feelings), you will call our office, report the problems, and schedule an appointment for a visit. If you experience extreme side-effects, seek emergency treatment and then notify our office after you have been discharged from the emergency room. Review all of the side-effects of your specific medications in your *Informed Consent for Medications* document.
7. You agree to notify our office if you receive any new medications from any health care professional. You also agree to notify our office if you experience new medical conditions, and you agree to disclose the names of all your health care providers and consent to our communications with these providers.
8. You agree that you will not share, sell, or otherwise permit others to have access to any medication you are prescribed. You agree to be very careful with your pain medications and to store them in a safe place, away from animals, children, and persons who have no business handling your medications.

9. You agree that you will not stop any medication without telling your doctor and receiving your doctor's approval to stop the medication. The only exception to this rule involves an emergency situation. You agree to follow the rules for emergency health care situations, as described below.
10. You agree to submit to urine or blood screens, if requested within 24 hours.

11. You agree to keep a medication log, detailing when you take your medications and how much of it you take. You agree to bring this medication log to every office visit for the purpose of reviewing it with your doctor or appointed medical staff.
12. You understand that we have discretion to decide whether it is medically necessary or medically prudent to replace your medications if: (1) you lose them, (2) report them stolen, (3) claim they were destroyed, eaten by the dog, washed away in a storm, or left on an airplane, etc. We will decide how to handle these reports on a case-by-case basis. We will ask you to write down what happened to your pain medications and sign your name to this document. We will keep this information in your medical file.
13. You agree to keep all scheduled appointments. You understand that if you fail to keep a scheduled appointment, you may not receive any more medications from this office. We will make decisions about medication refills on a case-by-case basis. We will ask you to write down the reasons why you missed a scheduled appointment and sign your name to this document. We will keep all such information in your medical file.
14. You understand that the use of any medication in your treatment plan is a trial, and that continued use of all medication is contingent on medical necessity and an analysis of the risks and benefits of medication usage in your particular medical case. *At all times, you have the right to choose to discontinue the use of pain medications, but you agree to tell us if you make this choice. At all times, you have the right to choose another health care provider, but you agree to tell us if you make this choice*.
15. If you have a medical emergency, you should seek immediate help. If you go to the emergency room for any reason, you agree to tell us about this event within 48 hours of your visit to the emergency room. If you cannot tell us about your emergency room visit, you agree that the individual family member/caregiver/significant other named below, will make this report to our office on your behalf. You consent to our request for documentation of your emergency treatment from the emergency room.
16. You understand that it is illegal to operate a motor vehicle if your ability to drive safely is impaired by alcohol or medication. You agree that you will not drive a motor vehicle until you have determined whether medications prescribed by this office impact your ability to drive safely. If you decide to drive, you understand that you assume all liability for any accidents arising from your unsafe operation of a motor vehicle. You agree to take a driving safety course, at your expense, and to report the results of this test to our office.
17. You agree to abstain from the use of alcohol while under treatment by this office.
18. You understand your doctor may advise you to use different forms of medication to treat your pain. You agree to follow your doctor's advice about these medications, subject, of course, to your consent for treatment using these medications.
19. By your signature, you are certifying to us that you have never been convicted of a crime involving drug abuse, drug diversion, conversion, sale, distribution, or illegal possession of drugs.
20. By your signature, you are certifying to us that you agree to truthfully disclose to your doctor all information relating to your history of substance abuse, if any, and all information relating to any family history of substance abuse.
21. By your signature, you are certifying to us that you have informed us of treatment or hospitalization for drug abuse, addiction, or overdose.
22. If requested to do so by your doctor, you agree to participate in a recovery program for substance abusers. If you decline to do so, your doctor may change your treatment plan and discontinue the use of pain medications. Alternatively, your doctor may decide to discharge you from his/her medical care.
23. If you have a history of substance abuse, you must agree to start or continue with a recovery program, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). If you decline to do so, your

doctor may change your treatment plan and discontinue the use of pain medications. Alternatively, your doctor may decide to discharge you from his/her medical care.

Consent to Speak with Others about your Personal Health Information

You are giving your consent for your doctor to discuss personal health information, including all diagnostic and treatment details, information about your pain medications and usage patterns, and information about your treatment agreement with this office, with any dispensing pharmacist and any other health care professional who provides health care services to you. The purpose of this term is to allow open communications between your health care providers about your medical history, current medical condition, treatment plans, and use of all medications, controlled and non-controlled. It is very important that we have the ability to communicate openly with other health care providers about your personal health information, so we can provide you with the best medical treatment possible for your pain condition.

By your signature, you agree to appoint a adult family member, friend, caregiver, or significant other who will participate in your treatment plan and help you with accountability issues related to your use of pain medication.

You give your consent to your doctor, or other employee of this office, to speak with law enforcement personnel, if asked, about your medical treatment and controlled substance medications. You are giving your consent for us to release all requested medical records to law enforcement personnel, if requested.

If you have a history of substance abuse, or if your doctor recommends that you undergo treatment for substance abuse, you give your consent to your doctor, or other employee of this office, to speak with your treatment facility or facilities and to obtain your treatment records.

In all cases above, we agree to keep your records in accordance with the law governing personal health information. You understand, however, you are giving us permission to discuss your personal health information with other health care providers, health care benefit plans and related third-parties as it relates to your medical treatment in this office, including discussions about billing and pharmacy benefits.

You understand you are waiving your physician-patient privilege for the purposes listed above. In certain cases, the law may be that you automatically waive your physician-patient privilege. If you desire more information about these consents and your physician-patient privilege, consult legal counsel.

Consequences of Failure to Follow Accountability Terms

If you fail to follow any of the terms in this agreement, we may decide to safely withdraw you from your pain medications, where medically appropriate to do so, and continue treating your pain without the use of controlled substances. You also understand that your failure to follow any of the terms in this agreement may result in your discharge from our medical care. We do not take patient discharges lightly and we will notify you, in writing, of the reasons for your discharge, should we decide this is the best option in your individual situation. We will keep a copy of any documentation relating to your failure to follow this agreement in your medical record.

Signatures and acknowledgement of copy received

Date:_____ Doctor signature:_____

Date:_____ Patient signature:_____

Date:_____ Family member/caregiver/significant other:_____

Date:___________ Witness signature:____