Patient ID: _____

PATIENT AGREEMENT BETWEEN PAIN SPECIALISTS OF GREATER CHICAGO & PATIENTS WHO ARE PRESCRIBED CONTROLLED SUBSTANCES TO TREAT CHRONIC PAIN

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (NARCOTIC pain medications), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because it is not certain whether they are beneficial when used to treat chronic benign pain. Patients who are prescribed these drugs have some risk of developing an abusive relationship with the medication or suffering a relapse of a prior history of substance abuse. The extent of this risk is not certain. Additionally, these substances have a narrow therapeutic window and the risk of accidental over dosage and death is high.

Because of the risk that a patient may have a substance abuse disorder and because of the risk of diversion of these medications to those with substance abuse disorders it is necessary to observe strict rules when they are prescribed on a regular and continuous basis. For this reason we require each patient receiving long-term treatment with these medications to read, understand in full, and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your chronic pain.

1. ***All opioids used to treat my chronic pain must come from a provider in this office***. My controlled substances will come from Pain Specialists of Greater Chicago unless specific authorization is obtained for an exception. I will notify my providers of all medications used to treat other conditions prescribed by any other care providers.

2. ***I understand that my physician and his/her staff will access the Illinois Prescription Monitoring Program (ILPMP)*** database for purposes of verifying that I am complying with the controlled substances policies of this office.

3. ***I will comply with any monitoring or restrictions that my physician requires.***

4. I will inform my physician/provider of any personal current or past substance abuse and any current or past substance abuse of any member of my immediate family.

6. ***I will inform the PSGC office of any new medications or medical conditions, and*** of any adverse effects I experience from any of the medications that I take.

7. I agree that my prescribing providers has permission to discuss all diagnostic & treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

8. ***I will not allow anyone else to have, use, sell, or otherwise have access to my medications.***

9. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

10. ***I will take my medication as prescribed & will not exceed the maximum prescribed dose***.

11. I understand that if I have medications left at the end of the month, I will notify the PSGC office so that my future prescriptions can be adjusted accordingly. I understand that I am not to "stockpile" my medications and that any excess medications or old prescriptions of controlled substances should be brought to the PSGC office for proper and documented disposal.

12. I understand that medications shouldn't be stopped abruptly, as withdrawal syndromes will likely develop.

13. **I will cooperate with unannounced urine or serum toxicology screens as may be requested. I understand that any evidence of tampering with these screens will affect my ability to be treated with controlled substances.**

14. I understand that the presence of unauthorized substances, the lack of presence of prescribed controlled substances, or the presence of any illicit substances on urine toxicology testing may prompt referral for assessment for a substance abuse disorder.

15. **I understand that these drugs may be hazardous or lethal to other people and animals and that I must keep them secure.**

16. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill.

17. **I understand that if I request an early refill secondary to lost, damaged or stolen prescriptions more than once within a year this is considered "red flag."** The consequences may include change or cessation of treatment with controlled substances, referral to an addiction specialist, urine testing and possibly discharge from the practice.

18. I understand that a prescription may be given early if the physician or the patient will be out of town or otherwise indisposed when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to appropriate date.

19. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substance administration.

20. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

21. ***I will make every effort to keep my scheduled appointments in order to receive medication renewals.*** I understand that regular and continuous monitoring is vital to my care and treatment while utilizing controlled substances and my failure to keep scheduled appointments may result in cessation of therapy with controlled substance prescribing by this physician.

23. I understand that any medical treatment is initially a trial, and that continued treatment with opioid medications is contingent on whether my physician believes that the chosen treatment is improving my clinical status.

24. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, tolerance and withdrawal. I have been explained the risks of over dosage including the possibility of respiratory arrest and death. I understand that there is evidence of other risks as well including hormonal side effects and enhanced sensitivity to pain in some cases.

25. ***I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accept all its terms.***

26. I am aware that attempting to obtain a controlled substance under false pretenses is illegal. I am aware that this is a felony.

27. I understand that at no time am I to operate heavy machinery, including driving a car, while under the influence of these medications or any other medications that may alter my judgment. I understand that there is the possibility of severe civil or criminal penalties if this occurs.

I attest that I have carefully read the above policy and have asked questions about anything I did not understand.

Patient signature: _____Date:_____

Provider Signature_____Date:_____