San Diego Pain Institute

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TREATMENT AGREEMENT & REFILL POLICY

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. **No prescriptions will be written for you unless you accept the following terms and conditions.**

Please initial next to each statement indicating you understand and accept these terms and conditions:

_____ 1. I, (your name) _____ understand that I am being treated at San Diego Pain Institute for **pain management only** and that the medical providers reserve the right to use their discretion in prescribing medications to treat my pain. I will seek and continue treatment with a primary care provider to manage my overall health concerns.

_____ 2. I understand that the possible complications of chronic opioid therapy may include:

-Constipation, dry mouth, nausea, vomiting, or decreased appetite;
-Dizziness, tiredness or lightheadedness;
-Respiratory depression;
-Muscle twitches, sweating, itching;
-Decreased urination;
-Decreased sex drive;
-Physical dependence;
-Addiction;
-Over dosage & death;
- (Females ONLY) — Chronic substance use may pose serious risks to fetus, therefore contact your provider immediately if you are or suspect you may become pregnant.

_____ 3. If I experience any of the following serious side effects, I will stop taking the narcotic and immediately seek emergency medical attention:

-An allergic reaction (difficulty breathing; closing of the throat; swelling of lips, tongue or face; hives);
-Slow, weak breathing; or any breathing difficulties;
-Seizures;
-Cold, clammy skin;
-Severe weakness or dizziness;
-Unconsciousness.
-Narcotics can be habit forming. Do not stop taking them suddenly.
NOTE: Side effects other than those listed here may also occur. Consult our doctor about any side effect that seems unusual or that is especially bothersome.

_____ 4. I agree to follow the dosing schedule prescribed to me by my provider. **Self-increasing my medication may result in my being without medication for a period of time or discharged from the practice.**

_____ 5. I will **never** share, sell or exchange my medication with anyone for any reason.

_____ 6. I understand that I am solely responsible for the safe keeping of my medications. I will treat my medications as I would any valuable possession. I know that **it is at San Diego Pain Institute's discretion to replace LOST OR STOLEN prescriptions or controlled medications, and that such situations will subject by case to a thorough *review* in addition to urine screens and random pill counts.**

_____ 7. I understand that I should not drive or operate heavy machinery while I am taking medications that are causing drowsiness or impaired cognitive function.

_____ 8. I agree to notify San Diego Pain Institute if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to San Diego Pain Institute for disposal.

_____ 9. I agree that if I receive a controlled substance prescription from San Diego Pain Institute, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.

_____ 10. I understand that my provider may routinely obtain Patient Activity Reports from the California Department of Justice, which provides a list of all controlled medications that are filled at all pharmacies. As a pain management patient, I acknowledge that I will be subject to random Urinalysis or Serum Toxicology and pill counts. I understand that there will be an additional cost of the Urinalysis/Serum Toxicology that I will be responsible for. If the results of the drug screen test positive for illegal drugs, or do not reflect medicine prescribed by my doctor, I understand that I may be referred for further assessment and/or dismissed from the practice.

_____ 11. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled appointment with my provider in the office, and telephone requests for narcotic medication refills will not be honored. I understand that if I run out of my narcotic medications due to overuse or loss of medications, I may not be able to obtain early refills. I understand that being without my narcotic medications can lead to withdrawal and other adverse effects, and may be required to go to the Emergency Room/Urgent Care if I experience any adverse effects from not having my medications. **For refill requests for non-narcotic medications, please allow 3-5 days to process.**

_____ 12. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a Pill Count.

_____ 13. I understand that San Diego Pain Institute may write narcotic medication prescriptions on a 30-day basis. In order to receive another narcotic medication prescription, I must schedule another office visit within 30 days (but no sooner than 28 days) of the date on my current prescription, so my doctor can properly evaluate my progress. Exceptions may be made at the provider's discretion ONLY.

_____ 14. I understand simultaneous consumption of opioids and alcohol can result in drowsiness, decreased alertness, and slowed breathing. If the drug screen test is positive for alcohol, I may be weaned off opioids and referred for alcohol counseling.

_____ 15. **I understand that my regular monthly refills will NOT be honored after regular business hours, over weekends or on holidays. In rare exceptions, a small amount may be written to meet the next appointment.**

_____ 16. The prescribing physician or physician's assistant has my permission to discuss all diagnostic and treatment details with my dispensing pharmacist or any other professionals who provides for my healthcare for the purposes of maintaining accountability.

_____ 17. I agree to use only **ONE** pharmacy for my pain-related medications. In the event that circumstances require the use of another pharmacy, I will notify San Diego Pain Institute immediately and provide them with all pertinent contact information.

The pharmacy I have selected to use is:

Pharmacy Name: _____Phone #:_____

Address/Location:_____

_____ 18. I will keep regular appointments and will call at least 24 hours in advance if I have to reschedule or cancel. I understand that failure to cancel a scheduled appointment 24 hours in advance and not showing up for a scheduled appointment **may** be subject to a charge of $25 for office visits and $50 for scheduled procedures.

_____ 19. I understand that medications may not be given for cancelled or no-show appointments. I also understand that if I am more than 10 minutes late to my scheduled appointment time, I **may** have to reschedule for another time, and may be subject to the No-Show fee.

_____ 20. I understand that **I** must have an appointment to be seen in the office.

_____ 21. San Diego Pain Institute phone triage hours are from 8:00am to 5:00pm, Monday through Friday for **NON-EMERGENCY medication questions and refill requests.** I understand that San Diego Pain Institute has a 24 hour Emergency Line and if for some reason I am unable to reach a provider that I will immediately go to the Emergency Room for evaluation and treatment.

_____ 22. I understand that abusive behavior or harassment toward any San Diego Pain Institute staff cannot and will not be tolerated. The physician will determine what action will be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.

_____ 23. I understand that dealing with a forged, falsified or altered prescription will result in my **immediate dismissal** from San Diego Pain Institute.

_____ 24. I authorize my pharmacy to cooperate fully with any City, State or Federal Law Enforcement Agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my provider to submit a copy of this agreement upon request. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ 25. Additional services and lab work, such as Urine/Blood Screens (UDS) will be billed separately from the standard office visit charge.

_____ 26. The risks and potential benefits of these medication therapies or procedures are explained elsewhere (and **I** acknowledge that I have received such explanation).

_____ 27. **I attest that I am not a risk to others or myself.**

By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and that I have read, understood and accepted these terms.

Non-compliance with this agreement can be terms for dismissal from the practice.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

_____ _____

Provider Signature Date