

MEDICATION CONSENT AND AGREEMENT

Note: Please write your initials next to each of the statements below after having read it.

- _____ **I agree not to call requesting medication refills over the phone.** I understand that no medications will be called-in, no prescriptions will be faxed, and no medications will be changed over the phone. I also understand that no new medications will be started over the phone. The only way that I will be able to get my prescriptions will be by keeping my appointments.
- _____ **I agree to request refills of my medications only during my regular appointment.** I understand that it is my responsibility to know how much medicine I have left, and whether or not I will have enough medication to last until my next appointment. Prescriptions will be provided only during my appointments. Should I forget to get my refills during my appointment would mean that I may not have enough medication to last until my next visit. I understand that should I get home and realize that I did not get my prescriptions; my pain physician will not be calling them in. I understand that I will need to get another appointment just to get those prescriptions.
- _____ **I agree not to request prescriptions or refills after normal business hours, nights, holidays, or weekends.** I understand that it is my responsibility to plan ahead, such that medications do not run out at night or during weekends.
- _____ **I agree to take medications only as prescribed or directed.** I understand that taking less pain medication than prescribed is acceptable, especially if I do not need as much to get the desired effect, or if I have problems and side effects with the recommended dose. However, I also understand that the opposite is not true. I should never take more than prescribed or directed, especially without the physician's expressed written consent. This consent can only be obtained from my physician during a regularly scheduled appointment. I understand that calling the clinics to obtain this consent over the phone is unacceptable and not recommended. I understand that there will be no early refills.
- _____ **I agree to always bring my medications to the appointments.** I understand that pills may be counted in order to assess my use of the medications. I also consent to having some of my medication be sent out for analysis and proper identification, on the sole discretion of my treating physician.
- _____ **I agree not to request and/or accept narcotics from any other sources.** I understand that this is called "Doctor Shopping" and it is illegal in the state of North Carolina. I agree to provide a list of all of my medicines to any physician offering such prescriptions, and never to attempt hiding or omitting to inform about any controlled substances that I may be taking.
- _____ **I agree never to share, give, lend, or sell any of my medication to anyone.** I also agree never to barrow or buy these medications from illegal sources. I understand that it is unwise, dangerous, and illegal. I understand that in the event that I was to break this agreement and resulted in a fatality, I will personally and solely be responsible, liable and held accountable for the other person's death.
- _____ **I agree to always bring a complete updated list of my medications to each appointment.**
- _____ **I agree to submit myself to random drug testing** as part of my medication management and monitoring. As part of my medication monitoring program, I also consent to sporadic pharmacy and background checks, which may include both criminal and for controlled substances.
- _____ **I agree to always check with my pharmacist whenever I am given a new medication,** to see if there may be any drug interactions with the other medications that I am taking. I understand that

over-the-counter medications and herbs may also interact with prescription drugs.

_____ **I agree not to use any illegal drugs** while being a patient of this program. These include, but are not limited to: marijuana; cocaine; crack; ecstasy; heroin; etc.. I understand and accept that the use of any illegal substances represents sufficient grounds for my dismissal from the program.

_____ **I understand that the pain clinic will not prescribe,** rewrite, or renew any medications that I may have received or may be taking for non-pain related reasons (blood pressure medicines, diabetes medication, asthma medication, nicotine patches, antibiotics, etc.). I understand that the pain clinic will write for pain medications only.

_____ **I understand that the pain clinic will not be writing for "nerve medicines"**. If I have problems with my "nerves" (anxiety, depression, nervousness, panic attacks, suicidal ideations, etc.) I understand that I need to see a psychologist or a psychiatrist for help. The pain clinic will not prescribe things like Valium (diazepam), Ativan (lorazepam), Xanax (alprazolam), or any other medicine for my "nerves".

_____ **I understand that lost or stolen medications will not be replaced.** I understand that the pain clinic does not accept police reports as evidence of medications having been stolen. Lost prescriptions will not be replaced.

I hereby certify that I have read this form or have had it read to me, that I understand all of it, and that I have had a chance to have all of my questions answered to my satisfaction. I certify that I have been given the opportunity to seek legal counseling, prior to signing this document. By voluntarily signing this form, I give my consent for the treatment of my pain with opioid pain medicines, and other medications commonly used in the treatment of pain. I also understand that signing this document does not mean that my pain physician is obligated in any way to prescribe or continue prescribing any of these medications to me. I also understand that failure to comply with the above regulations may result in the immediate discontinuation of the controlled substances being prescribed, as well as possible discharge from the program. I understand that this Agreement contains the entire agreement of the parties and supersedes and replaces all prior agreements between the parties and such other agreements shall be null and void and of no further force or effect. I also understand that this document is self renewable, on a yearly basis. I agree that should I decide to terminate this agreement, I will do so in writing. This agreement will go into effect when pain medications are prescribed by this program or its affiliates. This Agreement will remain in effect for the duration of my care.

Effective Date: Once you have signed this agreement, it will become effective the moment you receive any prescriptions from this program, at which time, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient signature _____ Date _____

Witness to above _____ MRN _____

RECEIPT OF MEDICAL INFORMATION:

I acknowledge having received and being responsible for listening to the content of the audio CD labeled "Medication Information" provided to me by **NC Pain Management Services PA**.

Patient signature _____ Date _____