



## Controlled Substance Medication Agreement

(1) **Richmond Spine Interventions and Pain Center** (referred to as RSIP) is dedicated to treating your chronic pain condition. This agreement is to protect both your access to controlled substances and how we prescribe medications for you. To receive or continue care, you and those involved in your care need to be familiar with all parts of this agreement. After you have read each paragraph please initial in the spaces provided. By initialing, you acknowledge that you understand and agree to abide by the corresponding statements. If you do not understand that statement please ask your RSIP provider to explain that statement. You will be asked to sign this document periodically throughout your care while you are being prescribed gabapentinoids/opioids or other controlled substances.

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(2) My RSIP provider is prescribing opioid medication, sometimes called narcotic analgesics, or other controlled substances for my condition. This decision was made because my condition is serious and/or other treatments have not helped my pain.

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### Controlled Substance Risk Awareness

(3) I am aware that the use of such medication has certain risks associated with it, including, but not limited to: sleepiness/drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, abnormally slow breathing rate, delay of reflexes or reaction time, addiction/physical dependence, tolerance to analgesia, and possibly incomplete pain relief.

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(4) The long-term use of substances like opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial due to uncertainties about their long-term benefits. Additionally, there is a risk of developing dependence or addiction, or of relapse in individuals with a history of addiction. The extent of this risk remains unclear.

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(5) Because these medications have the potential for abuse or diversion, strict accountability is necessary with prolonged use. For this reason, you, the patient, agree to the following policies as a requirement from the RSIP provider, whose signature appears below to initially prescribe or continue prescribing controlled substances for treating your chronic pain.

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### Long-Term Treatment Plan Regimen/Detoxification

(6) I understand that the goals of my pain management treatment plan include time-contingent use of narcotics and may include a weaning regimen to reduce dosage and dependence on these medications. While physical dependence is to be expected after long-term use of narcotics, signs of addiction (psychological dependence) will be interpreted as a need for weaning or detoxification.

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### Pharmacy

(7) **All** controlled substances must be obtained from the **same** pharmacy, whenever possible. The pharmacy must be legal and licensed in the United States. If you need to change the pharmacy on file, it is your responsibility to inform our office.

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(8) I understand that I am responsible for contacting other pharmacies if my usual pharmacy does not have my medication in stock. I will inform RSIP regarding the alternate pharmacy's information so RSIP providers can send my prescription to the alternate pharmacy.

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## Prescription Accountability, Medication Refills & Access

- (9) I will not alter or change my controlled substance prescription. I will take my medication as prescribed and I will not run out of my narcotic or controlled substance before the designated time the prescription is to be renewed. I understand that altering or abusing my prescription medication can result in harm or death to others or myself. I will not hoard my medications and I will let my RSIP provider know if I have leftover medications from my last prescription at each visit.

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## Keeping the Medications in a Secure Place

- (10) I will not share, sell, or otherwise permit others access to my prescribed medications. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. I will take the highest possible degree of care with my medication and written prescription. They will not be left where others might see or otherwise have access to them. **I will store my medications and prescriptions in a locked cabinet/safe. Only my responsible party and I will have access to the cabinet, key, and/or combination.**

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## Lost or Stolen Medications

- (11) I understand that narcotic prescriptions are **my responsibility**. If anything happens to my written or filled prescription (**stolen, thrown away, flushed, washed in the laundry, consumed by a pet etc.**) I am responsible. **NO** prescriptions will be written until the designated time the prescription is to be renewed.

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- (12) I will not hold any member of Richmond Spine Interventions and Pain Center liable for problems caused by the discontinuance of a controlled substance. If any prescriptions are lost or stolen, they **WILL NOT BE REPLACED**.

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## Medication Refill Policy

- (13) I understand that refills of controlled substance medication will be made only during regular office hours, in person, or during a scheduled visit.

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## Fridays, Weekends, and After-hours Refills

- (14) Refills will not be made during evenings, weekends, or holidays. An office visit is required for a refill of controlled substance medications. Refills will not be made if I **“run out early”**. I understand that I am responsible for taking the medication as prescribed and for keeping track of the amount remaining. Refills will not be made as an **“emergency”** such as on a Friday afternoon because I have suddenly realized **“I will run out tomorrow”**. I will call at least 2 weeks ahead for an appointment if I need assistance with a controlled substance medication. **I will not call the office for a medication refill on Fridays, any weekdays after 5 pm or on weekends.**

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## Prescriptions from Multiple Sources

- (15) **Multiple sources can lead to drug interactions, which can cause harm and possible death.** I understand that I am to obtain my narcotic or controlled substance prescriptions **ONLY** from **Richmond Spine Interventions and Pain Center**. I understand that if I violate this and obtain any narcotic or medication in any form from another source I will no longer be able to receive any further treatment from this practice.

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## When to Notify my RSIP Provider

- (16) I will notify my RSIP provider immediately if I develop serious side effects, become pregnant, am prescribed any new medications, or have been diagnosed with any new medical conditions (including any psychiatric diagnosis). If it is necessary for me to visit the emergency room due to pain, I should notify my RSIP provider as soon as possible after the visit. I further understand that if I have a problem with or a question about the above statement, I may make an appointment to discuss this with my RSIP provider and receive clarification before a crisis or problem arises.

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## Urine or Blood Screenings

- (17) I will not use, purchase, or otherwise obtain illegal drugs. I agree to submit to random urine and/or blood screens to detect the use of non-prescribed medications at any time. I understand that I must submit a urine and/or blood sample to the lab at the time specified by the provider. This time might range from 24 to 72 hours from the time the order was written.
- (18) I understand that the presence of illegal or legal substances such as marijuana, alcohol, cocaine, or the presence of any other controlled substances, which are not prescribed by my RSIP provider, in my urine or blood may lead to dismissal from the practice.
- (19) I understand that inconsistent urine or blood test results may be grounds for dismissal from the practice. An example of an inconsistent urine test result is: the presence of a medication not prescribed by the provider, an illegal substance present in the urine or blood, and/or the absence of the prescribed medication from the urine. I may be asked to do a repeat urine or blood test if there is an inconsistency in my original blood or urine test. I further understand that all urine and blood tests will be at my own expense.

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## Pill Counts

- (20) I may be asked to bring in medications at any time for a pill/patch count. I will be called and must report to the RSIP office within 24 hours with the correct number of pills/patches. Failure to present to the RSIP office could be grounds for discharge from the practice.

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## Activity Limitations/Restrictions

- (21) I will not participate in any activity that may be dangerous to me or someone else if I feel drowsy or if I am not thinking clearly. Such activities include, but are not limited to: using heavy equipment, operating a motor vehicle, or being responsible for another individual who is unable to care for him or herself. I am aware that even if I do not notice it, my reflexes and reaction time might still be delayed.
- (22) I understand that **state law prohibits driving and operating dangerous equipment while taking any sedating medication, even if you do not feel sedated.**

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## Right to Privacy

- (23) I waive my right to privacy so that the prescriber can contact **ANY** healthcare provider, pharmacist and/or legal authority to obtain/provide information about my care. The prescriber has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my healthcare to maintain accountability. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, from obtained medications at several pharmacies, all confidentiality is waived and the authorities may be given full access to my records.

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## Addiction Risk and Drug History Disclosure

- (24) I am aware that addiction is defined as the use of a medicine even if it causes harm, cravings for another drug, and/or feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is present. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has a family/personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge. I understand that a history of conviction in a drug-related crime will be a cause of dismissal from the practice and a conviction in any other crimes may result in dismissal from the practice as well.

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- (25) I will inform my RSIP provider if I or a member of my immediate family or any member of my household is using any illegal substances, cocaine, marijuana, or are misusing and/or abusing prescription drugs.

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- (26) I understand that physical dependence is a normal, expected result of using these medications for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some agents, I will experience a withdrawal syndrome. This means that I may experience all or any of the following: runny nose, yawning, large pupils, goosebumps, abdominal pain/cramping, diarrhea, irritability, body aches, or flu-like symptoms. I am aware that opioid withdrawal is uncomfortable but not life-threatening in most cases.

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## Analgesia Tolerance

- (27) I am aware that tolerance to analgesia means that I may require more medication to get the same amount of pain relief. I am aware that tolerance to analgesia is not a major problem for most patients with chronic pain, however, it has been seen and may occur to me, if it occurs, increasing my dose of the medication may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids/gabapentinoids may cause my prescriber to choose another form of treatment.

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## Effects of Chronic Opioids (Reproductive Health)

- (28) **[MALE]** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and/or sexual performance. I understand that my prescriber may check my blood to see if my testosterone level is normal.

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(29) **[FEMALE]** If I plan to become pregnant or believe that I have become pregnant while taking my pain medication, I will immediately call my obstetrician and my RSIP provider to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon gabapentinoids and opioids. I am aware that the use of opioids is not generally associated with the risk of birth defects, however, birth defects can occur whether or not the mother is taking medicine, and there is always the possibility that my child will have a birth defect while I am taking an opioid.

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### Policy Adherence

(30) It is understood that failure to adhere to these policies may result in termination of therapy of controlled substances, cessation of prescribing by RSIP providers, or referral for further specialty assessment. I give my consent to allow Richmond Spine Interventions and Pain Center to make inquiries and to receive reports from the Prescription Monitoring Program.

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My signature in this form specifies that I have read and understand the above agreement. I was given adequate time to review and sign this agreement. The risks and potential benefits of these therapies have been explained to me and my questions were answered. I affirm that I have the full right and power to sign and will be bound by this agreement and that I have read, understand, and accept all of these terms.

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party's Full Name: \_\_\_\_\_

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party's Contact Information: \_\_\_\_\_